Patient Registration Form

Patient's name: _____
Today's Date:_____(M)_____(D)_____(Y)

Age:_____

Please circle which applies below:

Birth Date ____ (M)____(D)_____(Y)

Single Married Divorced Minor Widowed

Social Sec. No._____ (we ask your SSN for checking insurance benefits purposes only)

Male Female Transgender Binary Others

I would prefer to be called: _____

Telephone:
HOME_____
CELL_____
WORK_____
Email: _____
**Please provide at least one alternative phone number in addition to your cell phone number.*

Street Address:
_____

City:_____ State_____ Zip_____

Patient/Parent's employer_____

Employer's Address:_____
_____

Present Complaint:
_____

Occupation:
_____

Who referred you?
_____

Spouse/Parent's Name:
_____

Dentist's name & phone
_____

Spouse's Social Sec. No.
_____

Spouse's Employer:
_____

Emergency contact person's name:
_____

Spouse's Position/Occupation:
_____

Address & Phone:
_____
_____

Dental Insurance Coverage:

Policy Holder's Name: _____
Policy Holder's Date of Birth:_____
Name of Insurance Co.
_____

Medical Insurance Coverage:

Policy Holder's Name_____
Policy Holder's Date of Birth:_____
Name of Insurance Co.
_____

I hereby assign, transfer, and set over to Prospect Oral Surgery Center all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Patient/legal guardian's signature:_____, Print Name: _____Date:_____

Prospect
Oral Surgery Center, LLC

Yuan (Cathy) Hung, DDS

312 Applegarth Road, Suite 202
Monroe Township, NJ 08831

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ **Home Telephone** _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ **Written Communication**
☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to number indicated

☐ **Work Telephone** _____
☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____
_____
_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

☐ Spouse
☐ Parent
☐ Child
☐ Other (specify): _____
☐ None

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

PROSPECT ORAL SURGERY CENTER **Weight: _____(lb.)**
Health questionnaire intake form **(Taken in office)**

Today's Date: _____(M)_____(D)_____(Year)

Name: _____ (First, Last)
Date of Birth: _____(Month)_____(Day)_____(Year)
Email address: _____

***PLEASE CIRCLE Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION.**

1. Who is your family physician? _____ Phone number?_____
When was your last checkup?_____. Do you see any medical specialists? Y N 2.
Have you had any:

a. **Surgeries (anywhere in the body)**?
Describe and give dates..... Y N

_____

_____

b.. **hospitalizations**? Describe and give dates: _____

_____

3. Have you ever had intravenous sedation or general anesthesia? .....Y N
Were there any adverse effects?(Nausea, vomiting, drug reaction, delayed recovery)... ..... Y N
4. Do you generally tolerate dental treatment well? If no, why Not?_____. Y N
5. **Have you ever had the following diseases? (circle all that apply):**

A. **Heart disease** that was detected **at birth** (congenital heart disease)?..... Y N
B. **Rheumatic fever** or **Rheumatic heart disease**? .....Y N
C. **Cardiovascular disease**: high blood pressure, chest pain, heart attack, heart failure, arrhythmia, any heart surgery including angioplasty, pacemaker, defibrillator placement)? Y N
Any other heart diseases? _____
Are you taking any **blood thinner (including Aspirin)? Y N
Which blood thinners?_____ Y N
High Cholesterol/Triglycerides? Y N
D. **Lung Disease**: asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, severe cough, COVID (active or recovered) Y N Others_____
E. **Neurologic Disorders**: seizure, epilepsy, fainting, dizziness, vertigo, multiple sclerosis? Y N
F. **Emotional problems**: anxiety, depression (including bipolar depression), psychosis, schizophrenia, other mood disorders _____. Y N
G. **Blood Disease**: bleeding disorder, factor deficiency (which one?) ____, anemia, blood transfusion Y N
What type of blood disease do you have?_____
H. **Liver Disease** (circle all that apply) Jaundice, fatty liver, cirrhosis, hepatitis (type)____, liver transplant Y N
I. **Kidney Disease** ? _____Y N a. Are you on **dialysis**? Y N Which days (M/W/F or T/Th/Sat)? b. Have you had a **kidney transplant**? Y N
J. **Diabetes**? What type?_____ What is your most recent hemoblogin A1C? _____ Y N
K. **Thyroid Disease** (hypothyroidism, hyperthyrodism, tumor) .....Y N
L. Arthritis: osteoarthritis, or rheumatoid arthritis? Y N
M. **Stomach or Intestinal problems**? (ulcer, acid reflux, hiatal hernia, colitis, IBS)..... Y N
N. **Glaucoma or other eye disease**?_____ Y N
O. **Implants/artificial joints** anywhere in your body (Heart valve, hip, knee)?.. .. Y N
P. **Radiation** for **cancer** anywhere? Y N (type of cancer)_____,
cancer in remission? Y N Radiation directly to Head and neck area? Y N
Q. **Chemotherapy?** Y N For what reason? _____,

R. Any **autoimmune** diseases? (Lupus, Sjogren's syndrome, rheumatoid arthritis, etc)
Other autoimmune diseases? _____ Y N
S. Any courses of **steroid treatment** currently or in the past two years? Y N
T. Noises or pain in jaw joint (**TMJ**) or pain near ear when chewing Y N
Do you grind or clench teeth? ..... Y N, Any trouble opening mouth or lockjaw in the past? Y N
W.. **Sinus or nasal problems**? ... Y N

6. Please list all of your current home medications (prescription and over-the-counter) AND any herbal supplements here (if you have a list of medications, please hand to our receptionist)
_____7.
Are you **allergic** (Rash, hives, difficulty breathing) to any drugs and or food? Y N
Describe the reactions to individual drugs/food:
Drugs:_____
Food:_____

8. Do you consume **alcohol**? How much and how often?_____Y N
9. Do you or have you ever **smoked cigarettes/cigars**? Y N , one pack of cigarettes lasts how long?_____ , Ex-smokers: When did you quit?_____, How much did you smoke in the past ?_____for how many years?_____ Do/Did you use **spit tobacco**? Y N For how long? _____, Do/Did you chew **betel nuts**? Y N , Do you **vape**? Y N
10. Do you or have you used any **recreational drugs (cocaine, heroin, LSD, marijuana, meth, etc)** before? Which ones?_____ Y N Have you used **intravenous** drugs? Y N
11. Do you use **prescribed medical marijuana**? Y N
12. Are you under the care of a **pain management specialist** for any reason? Y N
13. . Are you or have you been in any inpatient/outpatient **drug rehab programs** before? Y N
14.. Have you been diagnosed with **osteopenia** or **osteoporosis** in the past? Y N
15. Have you ever been on any antiresorptive drugs for treatment of osteoporosis or bone cancer, either by mouth or via injection/infusion (eg. Fosamax, Boniva, Actinel, Prolia, Zometa, Xgeva, etc) Y N For how long? _____ Have you been switched from one type to another over the years? Y N When was the very first time you were prescribed and taken these types of medications? _____
16. **(Female patients only):**
A. Are you taking birth control pills? ..... Y N
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? .....Y N
C. Are you currently breastfeeding?.....Y N
D. Are you taking hormonal replacement? ..... Y N
17..Are there any other medical diagnoses that were not covered in the questionnaire? _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____ _____

Patient's name (Print) Signature Date Doctor's initials

If someone other than the patient filled out the questionnaire please print your name and state your relationship with the patient: (Name, relationship to patient)

_____

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Office Financial Policy

Patient's name:_____ Responsible party's name:_____, Today's Date:_____

Important: Please provide us with both of your dental AND medical insurance information. Oral surgery procedures may be covered by dental and/or medical insurances depending on your coverage.

Basic Policy: Payment for services rendered **is due in full on the day of service.** Our office accepts cash, personal checks (with valid Driver's license) and credit cards. **We do not accept personal checks more than $1000 due to bounced check issues in the past. Please prepare a cashier's check or use credit cards.** There is a **$30 returned check fee** due to and payable from you for each check payment returned to us by your bank. *If someone else is paying for your treatment, the check holder needs to be present with a valid Government ID in order for us to process the check.* We carry third party financing, please inquire within. We do not accept installments. You may prepay your treatment fee at the time of your scheduling if you wish to do so.

For patients with insurance: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. **Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Preauthorization does not guarantee insurance payment.** Insurance companies may decide not to pay for part or all of the treatment at their discretion. Please understand that insurance is a contract between you (your employer) and your insurance company. **If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you**. If your insurance carrier shall make payment after 60 days, you will be reimbursed for the difference. If you are truly experiencing any financial difficulties, please contact our office to discuss payment options.

Managed Care participants: some benefits plans require pre-authorization and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All copayments or patient out-of-pocket fees are due and payable at the time of service.

Medicare patients: Majority of the time Medicare does not cover dental extractions. We are not a participant with Medicare at this time. You will be responsible for the out-of-pocket expense unless otherwise covered by your insurance.

Surgery fees: All copayments, deductibles and payments for non-covered surgical procedures are due on the day of the surgery. Your insurance carrier may require prior authorization. Our fee schedule is set based on the time,

quality of care and the expense of the supplies in order to provide the highest standard of care to you. **A $250 non-refundable deposit (or entire amount of copayment up to $250 if less than $250)** is taken at the time of scheduling for certain surgical procedures such as third molars with sedation, dental implants, bone graft, etc. Please understand that a block of time is reserved for your surgery. If you should need to schedule, please allow at least 24 hours of notice (business days, not calendar days). The office reserves the right to request for a **COVID test (PCR) for patients symptomatic of upper respiratory symptoms.** The patient is responsible for the cost of COVID test at a local lab. We cannot accept home test results.

Workers compensation: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

Overpayment: occasionally, your insurance carrier may overpay for the procedure. In which case, we will handle the refunds either to you, or to the insurance carrier, at the discretion of your insurance carrier. Overpayment can occur when multiple insurance carriers are involved and more than one company pays for the same procedure codes. A refund may be issued once the final Explanation of Benefits is finalized.

We thrive to achieve the best quality of care for you. Please understand that insurance policies are complicated and can be time-consuming. **Pre-treatment estimates may not reflect how insurance carriers pay out. Please be patient and do not threaten or be verbally abusive to our staff members.** Thank you.

Pathology specimen: when a pathology specimen is submitted to an outside lab due to a biopsy procedure, whether alone or in combination of another procedure (Example: cyst associated with a tooth), **you will receive a separate billing statement from an outside lab for the examination and the report of the specimen. We do not have control over how the lab might bill you**. Our pre-treatment estimate only reflects the surgery portion of the fee, not the pathology report. Please contact the pathology lab directly to inquire about their billing statement.

Additional paperwork for the employer (disability, time-off) is $15 for less than 10 pages and $25 for more than 10 pages. The paperwork will be filled out after the procedure. A complementary doctor's note from our office may be requested for your missed days.

I have read, understood, and agree to the above financial policy for payment of the professional fees. I understand that I am ultimately responsible for all fees for services provided to me.

Guarantor/Patient's Name (Please Print): _____

Guarantor/Patient's signature: _____

Assignment of insurance benefits: Patient with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Hung. This Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all the charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor/Patient's signature: _____

Date: _____ Rev. 1/24

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Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities: The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you **(over)**
- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact us at 609-860-6369.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website-

If we maintain a website that provides information about our entity, this Notice will be on the website.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date

Effective March 09

Informed Consent for Opioid Use

I have agreed to use opioids as part of my treatment to manage dental related chronic or post operative pain. I understand that these drugs are useful in managing my pain, but have a high potential for addiction and/or dependency.

I understand that I can discuss possible alternatives for this opioid prescription with my dental prescriber and have furnished a complete and accurate medical history (including pregnancy, if applicable) and list of the medications I currently am taking or have taken in the last 6 months, including information about mental history and drug and/or alcohol use by me and members of my family.

Because my dental provider is prescribing such medication to manage my pain, I acknowledge that I have been made aware of the following information and agree to the following conditions:

1. I am responsible for my pain medications and agree to take the medication not more frequently than as prescribed and only if needed to manage pain. I understand that increasing my dose without my dentist's knowledge could lead to a drug overdose causing severe sedation and respiratory depression and possibly death.

2. Without prior disclosure to my dental provider, I will not request or accept controlled substance medication from any other healthcare provider or individual while I am receiving such medication from my dental provider.

3. There are side effects with opioid medications, which may include, but not be limited to, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, confusion, depression, increased sensitivity to pain or the possibility of impaired motor ability. As a result, when I take these medications, it may not be safe for me to drive a car, operate machinery, or take care of other people.

4. I have been made aware that I may become addicted to these medications (opioids) and may require addiction treatment. Overuse of this class of medication can lead to physical dependence and the experience of withdrawal sickness if I stop use or cut back too quickly. Withdrawal symptoms feel like having the flu and may include: abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety and sleep problems.

5. I understand that the opioid prescription I have been given is for my own use and attest that I will not give or sell any portion of the prescription to another individual.

_____ _____

Patient, Parent or Guardian Signature Date