NEW PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____ Sex _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone Numbers: Home: _____ Business: _____ Extension _____
Employer _____ Employer Address _____
Social Security # _____ Driver's License # & State _____
E-Mail Address _____ Cell Phone # _____

Account Responsible Party, if not patient:

Guardian _____ Date of Birth _____ Relationship _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone Numbers: Home: _____ Business: _____ Extension _____
Employer _____ Employer Address _____
Social Security # _____ Driver's License # & State _____
E-Mail Address _____ Cell Phone # _____

Emergency Contact

Name/Relationship _____/_____ Daytime Phone: _____
Address _____ City _____ State _____ Zip _____

Insurance Information

MEDICAL

Insurance Co. _____
Address _____
_____
Phone Number: _____
Insured Party Name _____
ID # _____ DOB _____
Group # _____ Employer _____

DENTAL

Insurance Co. _____
Address _____
_____
Phone Number: _____
Insured Party Name _____
ID # _____ DOB _____
Group # _____ Employer _____

Fees & Payments

Payment is expected at the time services are rendered. A pre-determination of your insurance benefits and coverage will be obtained by this office prior to any treatment; however, this is based upon information received from your insurance company and is not a guarantee of payment. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by, or denied by, your insurance company.**

I hereby authorize the release of information necessary to process the claim(s). I authorize the use of this signature on all of my insurance claims, manual or electronic. I further authorize payment to the Pinnacle Oral Surgery, the benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered in full, regardless of payments expected by an insurance company.

Signature _____ Date _____

CONSENT AND DIAGNOSTIC AIDS

I hereby give my consent to Pinnacle Oral Surgery, for any diagnostic aids necessary to evaluate, document and/or diagnose my condition. These shall include, but are not limited to, radiographs, models, and photographs. I further give Pinnacle Oral Surgery, any medical or dental information necessary to evaluate and/or treat my condition.

Signature _____ Date _____

PINNACLE
ORAL SURGERY SPECIALIST
WISDOM TEETH – DENTAL IMPLANTS

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Dentist: _____ Email Address: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY

____High Blood Pressure	____Sinus Trouble	____Blood Disorder
____Heart Murmur	____Fainting Spells	____Epilepsy or Seizures
____Heart Disease	____Ulcer/Colitis	____Stroke/TIA
____Heart Attack	____Hepatitis A/B/C	____Thyroid Problems
____Rheumatic Fever	____Liver Disease	____Back/Neck Injury
____Ankle Swelling	____Diabetes Type I or II	____Arthritis
____Shortness of Breath	____Kidney Problems	____Tumor/Cancer (anywhere)
____Pneumonia	____Anemia	____Radiation/Chemotherapy
____Tuberculosis	____Hemophilia	____Aids or HIV+
____Asthma	____Emphysema	____Blood Transfusion

WOMEN:
Are you pregnant? _____ Are you nursing? _____ Taking birth control pills? _____
(Note – Antibiotics may neutralize the effects of birth control pills, theoretically allowing for conception and pregnancy)

OTHER MEDICAL PROBLEMS: _____

LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES: _____

_____

PROBLEMS WITH PREVIOUS GENERAL ANESTHESIA/IV SEDATION: _____

CURRENT MEDICATIONS: _____

_____

HAVE YOU TAKEN ANY DRUG(S) FOR OSTEOPOROSIS? _____
HAVE YOU **EVER** TAKEN ANY OF THE FOLLOWING MEDICATIONS? _____

____ Aredia	____ Fosamax	____ Actonel	____ Boniva
____ Zometa	____ Ostac	____ Skelid	____ Didronel

ALLERGIES TO MEDICATION: _____
ALLERGIC TO LATEX: _____ ALLERGIC TO SOY OR EGG: _____

DO YOU SMOKE/CHEW? _____ If yes, packs per day: _____ How many years: _____

ARE THERE ANY OTHER CONDITIONS CONCERNING YOUR HEALTH THAT YOUR DOCTOR SHOULD BE AWARE OF? _____

I have read and fully understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully. I will not hold Pinnacle Oral Surgery, or any member of the staff, responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE: _____ DATE: _____ Rev. 6/19

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PINNACLE ORAL SURGERY

469-698-9800 • www.PinnacleOMS.com
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804 Gilmer Street • Sulphur Springs, TX 75482

Ketan P. Parekh, DDS David D. Martinez, DMD, MD

GENERAL ANESTHESIA & INTRAVENOUS SEDATION INSTRUCTIONS

May complex surgical procedures are most comfortable and safely performed with the assistance of intravenous (IV) medications. This methoid of general anesthesia or "twilight sleep" produces optimum comfort and relaxation, thus making the surgical procedure more pleasant for the patient and technically easier for the surgeon. Patients who receive IV medications in the surgeon's office always remain in a "recovery" area and are observed by the professional staff until the effects of the medication have dissipated enough to allow the patient to safely leave the office accompanied by the responsible adult. It should be noted, however, that the effects of the IV medications can persist for up to 24 hours after dismissal from the office.

Patients receiving IV medications should wear loose fitting clothing (**INCLUDING A SHIRT WITH SHORT SLEEVES**) on the day of surgery and **must** be accompanied by an adult who is present in the reception area during the entire surgery and who can drive them home. Patients who wear false nails or nail polish should remove them pre-operatively. **Finally, patients receiving IV medications must not have anything to eat or drink for at least 6 hours before their surgery except for a small sip of water to take needed medications (i.e., pills for high blood pressure, diabetes, etc.). Patients are to take all regular medication, unless instructed otherwise.**

The following instructions are given for those who will be accompanying and/or caring for patients who have received IV medications in the office. These persons should:

1. Accompany the patient on the day of their surgery and remain in the office reception area during the entire surgery until the patient is discharged into their care.
2. Provide direct assistance in walking the patient (i.e., arm support) and transporting the patient to or from any bed or seated area. A bed or seated area should be chosen that limits the potential for the patient to fall out and to minimize injury should this occur. A bed or sofa close to the floor usually is the best choice.
3. Keep the patient under continuous observations for at least 3 hours following dismissal from the office. After 3 hours, observe the patient at least every 15 minutes for 2 additional hours.
4. Assist the patient to closely follow the doctor's post-operative instructions regarding medications, dressing, rest, diet, ice packs, etc.
5. Assure that the patient does not operate a motor vehicle or other heavy machinery for at least 24 hours following the surgical appointment.
6. Call the office at the above number should any questions arise during the recovery period.

THE ABOVE INFORMATION HAS BEEN EXPLAINED TO THE PATIENT AND/OR GUARDIAN AND IS FULLY UNDERSTOOD.

SIGNATURE	RELATIONSHIP	DATE

STATEMENT OF PRIVACY PRACTICES

PINNACLE ORAL SURGERY SPECIALIST

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Texas. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Pinnacle Oral Surgery Specialist. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Pinnacle Oral Surgery Specialist reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	