WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(_____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

STOP! DETACH THIS TOP SHEET ONLY, AND BRING IT TO THE FRONT DESK BEFORE PROCEEDING.

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit?_____

		Yes	No
1.	***Height***_____ ***Weight***_____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated?_____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe_____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where_____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where***_____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Acid reflux?			
51. Stomach / GI troubles / ulcers / IBS / colitis?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of marijuana or other drug use?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 67–70)*

67. Is there a possibility of pregnancy? ❑ Yes ❑ No
68. Expected delivery date?_____
69. Are you nursing? ❑ Yes ❑ No
70. Are you taking birth control pills? ❑ Yes ❑ No

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
1. Any kind of medication, drug, pills?			
2. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
3. Have you ever taken diet pills?			
4. Any natural product, herbal supplement or homeopathic remedy?			
5. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			

6. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

7. If you are under the care of a physician for pain management, or recovering from drug addiction, select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other
Treating doctor:

8. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
79. Local anesthetic (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics?			
82. Sulfa drugs?			
83. Sodium pentothal / Valium /other tranquilizers?			
84. Aspirin?			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Latex?			
88. Soy?			
89. Eggs / yolk?			
90. Sulfites?			
91. Do you have any known allergies?			

92. Please list any allergies other than drug allergies:

93. Please list any other medication or antibiotic you are allergic to:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Name of attorney / adjustor _____

Tel (_____) _____ Claim number _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date** X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)* X _____ **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Witness** X _____ **Doctor** X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

ATLANTIC
Oral Surgery & Implant Center
Jeffrey H. Wallen, D.D.S.

Medical Information Release Form
(HIPAA Release form)

Name: _____ **Date of Birth:** _____

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Children _____

( ) Other _____

OR

( ) Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell number _____

If unable to reach me:

( ) you may text me

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

I understand that this office will try to accommodate my wishes about my contact information but may have to contact me at the other numbers if unable to contact me at my requested number/location.

Electronic Communication

I agree that Atlantic Oral Surgery & Implant Center may communicate with me electronically at the email address below. I am responsible for providing any updates to my email address.

Email address (Please print clearly):

_____

Patient Signature: _____ **Date:** _____ / ____ / _____

Witness (Office Use Only) _____ **Date:** _____ / ____ / _____

ATLANTIC
Oral Surgery & Implant Center
Jeffrey H. Wallen, D.D.S.

MEDICARE

This is to inform you that this office DOES NOT PARTICIPATE with MEDICARE.

Unfortunately, we are not able to file a claim with Medicare and Medicare will not reimburse you for procedures performed by this office.

Signature: _____

Date: _____

Witness: _____

Atlantic Oral Surgery and Implant Center

NOTICE OF PRIVACY PRACTICES

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.

Your Health Information
Your patient health information is confidential and protected by law. Patient health information includes information regarding your symptoms, test results, treatment, diagnosis, and related medical information. Your health information also includes information about payment, billing, and insurance.

How Your Health Information is Used
Your health information is used to provide you with treatment, to obtain payment, and to conduct health care operations, such as evaluation of the quality of care received by Practice's patients. Under some circumstances, your health information may be used or disclosed even without your permission.

Examples of Treatment, Payment, and Health Care Operations Where Your Health Information May Be Used or Disclosed Without Your Consent
Treatment: Your health information is used to provide medical treatment or services to you. Physicians, nurses, and other members of your treatment team record information in your record and use it to determine the most appropriate course of care. The information may be disclosed without your permission to other health care providers, such as physicians, clinical laboratories, and pharmacists, so they may provide you with treatment.

Payment: Your health information is used without your consent to obtain payment for services provided to you. For example, your insurance company may require us to provide information about proposed treatment before the insurance company will authorize payment. We will also use your health information without your permission in order to submit bills and maintain records of payments from your health plan.

Health Care Operations: Your health information is used without your permission to conduct health care operations, so that we can properly administer our records, evaluate the quality of treatment, and assess the care and outcomes of your case and others like it. We may also use and disclose your health information without your permission to contact you as a reminder that you have an appointment with us, and to tell you about health-related benefits and services that may be of interest to you. For example, we may contact you about new testing services available based on services ordered by your physician.

Other Uses and Disclosure of Your Health Information That Can Be Made Without Your Permission
Sometimes your health information may be used or disclosed for other reasons, even without your consent. Subject to certain requirements, health information may be disclosed without your permission for the following purposes:

- *Required by Law*: Certain laws may require us to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities*: We may be required to disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health oversight*: We may be required to disclose information to assist in audits and investigations by government programs and agencies.
- *Subpoenas and judicial proceedings*: We may disclose information in response to an appropriate subpoena or court order.
- *Law enforcement*: We may disclose information required by law enforcement officials, subject to certain restrictions.
- *Deaths*: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious threat to health or safety*: If necessary, we may use and disclose information to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions*: We may release information about armed forces personnel as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- *Research*: We may use or disclose information for certain approved medical research.
- *Workers Compensation*: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

- *De-identified Information and Limited Data Set*: We may use and disclose your health information that has been "de-identified" by removing certain identifiers making it unlikely that you could be identified. We may also disclose limited health information contained in a "limited data set" as that term is defined in the privacy regulations. The limited data set would not contain any information that could identify you. For example, a limited data set may include your city, county, and zip code, but not your name or street address.
- *Family Members*: Unless you object, we may share your health information without your permission with family members and other caregivers to assist them in providing you with care.
- *Employer*: If we perform a work-related evaluation at the request of your employer, we may disclose the results to your employer.

All Other Uses and Disclosures of Your Health Information

For all purposes not described above, including most uses and disclosures of psychotherapy notes, uses and disclosures of your health information for marketing purposes, and disclosures that would constitute a sale of your health information, we will ask for your written authorization and will only use or disclose your health information if we receive a written authorization from you. You are not required to sign an authorization, but if you choose to do so, you may revoke it, in writing, at any time to stop any future uses and disclosures, except to the extent that action has been taken in reliance on the authorization.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed in the box below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We must agree to your request to restrict disclosure to a health plan if the disclosure pertains solely to an item or service paid for out-of-pocket in its entirety by you or another person or entity on your behalf. For other restrictions, with limited exceptions, we are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communication: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. You must make your request in writing. We have up to 10 days to make your health information available to you, and we may charge a reasonable fee for the copies. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If we deny access to your health information, you will receive a timely, written denial explaining the basis for the denial, your review rights, and how to exercise those rights.

Right to an Electronic Copy of Electronic Medical Records: If your health information is maintained in an electronic format, you have the right to request that an electronic copy be given to you or transmitted to another individual or entity. We will make every effort to provide the electronic copy in the format you request, however, if it is not readily producible by us, we will provide it in either our standard format or in hard copy (fees may apply).

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Health Information Breach Notification: You have the right to receive, and we are required to provide you with, written notification if we discover a breach of your unsecured health information, unless that is a demonstration, based on a risk assessment, that there is a low probability that your health information has been compromised. You will be notified without unreasonable delay and no later than 60 days after discovery of any breach of your unsecured health information. Such notification will include information about what happened and what can be done to mitigate any harm.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed in the box below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of

Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any question, requests, or complaints, please contact:

Name: Tristan Everts

Title: Practice Manager

Address: 61200 48th Ave. N., Suite 101| Myrtle Beach, SC 29577

Phone: 843.449.4993

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE UPON REQUEST.

EFFECTIVE DATE OF NOTICE: May 13, 2022