Memphis Oral and Maxillofacial Surgery Group, PLLC

Ronald C. Staples, DDS, FACS
J. Olayinka Majekodunmi, D.D.S. Richard D. Meekins, Jr., D.D.S. Matthew J. Breit, D.D.S.

Patient's Account # _____ Date ___/___/__
Guarantor Account # _____

Patient's Name_____

Patient's Address_____City____State___Zip___

Phone # ( ) _____-____ Birthdate ___/____/_____ Soc. Sec. # ___-__-____

Patient's Employment_____Phone # ( ) ___-___

Patient's School _____City_____State_____Zip____

Patient's Marital Status: Single_____ Married ___ Divorced___ Widowed___

Email Address: _____

Responsible Party's Name: _____

Address: _____City _____State ____Zip____

Responsible Party's Employment _____Phone # ( )____-___

Employment Address: _____City _____State ____Zip____

Patient's Relationship to Responsible Party _____

In Case of an Emergency, Please Notify _____Phone # ( ) ____-___
(Someone not living in same household)

Dental Insurance Coverage
Insurance Company _____Group Number _____
Name of Insured _____Policy # _____
Relationship to Patient_____
Insurers Date of Birth _____SSN # _____

_____
Who referred you to our office

HEALTH HISTORY

Patient's Name _____ Date _____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder, Autism, ADHD? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - S. HIV, AIDS or ARC? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   - I. Any regular medicine, pills or drugs – either over-the-counter or prescription. If Yes please list: ..... Y N

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials

Center for Oral and Facial Surgery of Memphis, PLLC
1251 Wesley Dr. Suite 101
Memphis, Tennessee 38116
2900 Kirby Parkway, Suite 10
Memphis, Tennessee 38119
Telephone (901) 398-0793
Fax (901) 398-0222
www.MemphisOralFacial.com

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All Surgeons are certified by the American Board of Oral and Maxillofacial Surgery

Payment Agreement

Patients with Medical/Dental Insurance

Most health insurance plans will not pay for the entire cost of your care. Our trained staff will gladly assist you in filing your claim so that you may receive the maximum allowable benefits for your treatment and reduce your out of pocket costs. Insurance plans vary considerably and your coverage may be reduced by a number of plan policies. These may include yearly deductibles, co-payments, a dollar limit for covered services, a yearly allowance for required x-rays, a yearly maximum benefit amount and many other plan obligations.

Because we have no way of knowing with certainty exactly how much your insurance will pay toward your bill we will estimate your portion based on the information we have at this time. **It is our policy to inform you of the total cost of treatment and collect all estimated patient payments prior to the administration of anesthetic agents.** Our office accepts cash, checks, all major credit cards, debit cards and selected health credit cards. Ultimately, financial obligations for treatment are your responsibility and all accounts are to be paid in full within one month (30 days) regardless of your insurance status.

In the event that you do not receive the benefits to which you believe you are entitled from your insurance carrier, we suggest that you contact your carrier and your employee benefits representative to request the appropriate professional review. If we can be any assistance to you in these endeavors, we will make every effort to do so.

Patients Paying with Personal Checks

Please note that due to the number of bad checks our practice has received recently, our office participates in the **Shelby County District Attorney General Office's Hot Check Program.**

The District Attorney's office has stated that bad checks written for medical/dental services and insurance co-payments are a criminal act and offenders will be arrested and prosecuted. Our office will automatically forward all bad checks over to the DA's office for action.

I am fully responsible for services rendered by Center for Oral and Facial Surgery of Memphis, PLLC. If collection costs are incurred to collect my account, I will pay the additional charge and all court costs and attorney's fees associated with the collection of the balance.

Assignment and release: I hereby authorize my insurance benefits to be paid directly to the surgeon.

_____ Date_____
Responsible Party's Signature

_____ Date_____
Witness Signature

Center for Oral and Facial Surgery

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I, _____have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____
_____
_____

Center for Oral and Facial Surgery
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACC PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization white it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of you location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so (you must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $00.10 for each page, $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this account more that once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by your agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative location (you must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electric Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Richard D. Meekins, Jr., DDS – Privacy Officer

Telephone: (901) 398-0793 Fax: (901) 398-0222

Email: _____

Address: 1251 Wesley Dr. Suite 101, Memphis, TN 38116

This form is educational only, does not constitute any legal advice, and covers only federal, not state law (August 14, 2003).

Center for Oral and Facial Surgery of Memphis, PLLC

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J. Olayinka Majekodumni, D.D.S.

Richard Meekins, Jr., D.D.S.

1251 Wesley Dr., Suite 101
Memphis, TN 38116

2900 Kirby Parkway, Suite 10
Memphis, Tennessee 38119

CONSENT FORM

PLEASE READ THIS DOCUMENT AND FEEL FREE TO ASK ANY QUESTIONS YOU MAY HAVE BEFORE YOUR SURGERY.

You have the right to be informed about your diagnosis and planned surgery so that you may make a decision whether to undergo the procedure after knowing the risk and hazards.

POSSIBLE (but not limited to) COMPLICATIONS TO ORAL SURGERY

SWELLING, BRUISING AND PAIN – These can occur with any surgery and vary from patient to patient and from one surgery to another.

TRISMUS - This is a limited opening of the mouth due to inflammation and/or swelling in the muscles. This is most common with impacted tooth removal, but it is possible with almost any surgery. It can last from a few days to several weeks.

INFECTION – This is possible with any surgical procedure and may require further surgery and/or medications in the event it does occur.

BLEEDING – Although significant bleeding can occur during or after surgery, it is not common. Some bleeding is, however, usual for most surgeries and is normally controlled by following the post-operative instructions.

DRUG REACTION – A reaction is possible from any medication given and could include nausea, rash or other allergic reactions.

TMJ DYSFUNCTION – This means that the joint of the jaw (TMJ) may not function properly, although rare, any required treatment ranging from moist heat and rest to joint surgery.

DRY SOCKET – This is significant pain in the jaw and/or ear due to loss of the blood clot and most commonly occur after the removal of lower wisdom teeth, but it is possible with an extraction. This may require additional office visits to treat.

DAMAGE TO OTHER FILLINGS AND/OR TEETH – Due to the close proximity of the teeth, it is possible to damage other teeth as well as fillings when a tooth is removed.

SHARP RIDGES OR BONE SPLINTERS – Occasionally, after an extraction, the edge of the socket will be sharp, or a bone splinter will come out through the gum. This may require another surgery to smooth or remove the bone splinter.

INCOMPLETE REMOVAL OF TOOTH FRAGMENTS – There are times the doctor may decide to leave a fragment of root of a tooth in order to avoid doing damage to adjacent structures such as nerves, sinuses, etc.

JAW FRACTURE – This is an extremely rare occurrence, but can happen if certain conditions exist, such as a tooth in an extremely thin jaw or in an elderly patient with brittle bones, etc.

WOMEN OF CHILDBEARING AGE – After your surgery you may be prescribed an antibiotic. Studies have shown that women who take birth control pills and antibiotics at the same time may become pregnant. Antibiotics may make birth control pills not work for up to one month after your next cycle.

UNUSUAL COMPLICATIONS – Occasionally complications occur that are exceeding rare during surgery. Such complications are also possible during oral and maxillofacial surgery.

LOWER TEETH

NUMBNESS – Due to proximity of roots of the lower teeth to the nerve of feeling to the lower lip, teeth, gums, and tongue, it is possible to bruise or damage the nerve with the removal of a tooth. This would cause numbness that could last for a few days to several months and rarely but possibly permanent numbness. The affected area, such as the lip, the tongue or the chin, could feel numb, tingly, or have a slight burning sensation.

UPPER TEETH

SINUS INVOLVEMENT – Due to the location of the roots (especially the upper molars) to the sinuses, it is possible for an opening to develop from the sinus to the mouth, or a root may be displaced into the sinus. This may require medication and/or additional surgery.

ANESTHESIA

LOCAL ANESTHESIA – Certain possible risks exist which, although uncommon or rare, could include pain, swelling, bruising, infection, nerve damage, or unusual or allergic reaction.
GENERAL ANESTHESIA/IV SEDATION – Certain possible risks exist which although uncommon, could include nausea, pain, and swelling. Complications could include Phelbitis (vein inflammation) and allergic or unusual drug reactions.

THIS DISCLOSURE IS NOT MEANT TO ALARM OR FRIGHTEN YOU. IT IS SIMPLY AN EFFORT ON OUR PART TO MAKE YOU BETTER INFORMED SO THAT YOU MAY KNOWLEDGEABLY GIVE OR WITH HOLD YOUR CONSENT TO THE SURGERY.

PATIENT NAME:_____
I hereby authorize Dr. Staples/Dr. Breit/Dr. Meekins/ Dr. Majekodunmi to perform the following:_____
_____
_____

I have read and discussed the risks and complications which may occur in connection with this procedure. We have discussed the alternate methods of treatment. I believe I have been given and understand sufficient information to give my consent to the above surgery.

Signature: _____Date ____/____/_____
Patient, Parent or Legal Guardian

Signature: _____Date ____/____/_____
Witness

Signature: _____Date ____/____/_____
Provider of Services