PINEY POINT ORAL & MAXILLOFACIAL SURGERY OF KATY-CYPRESS, PLLC

Steve L. Koo, DDS | William D. Shepard, DDS, MD

Date _____ Patient's Name _____

SINGLE ☐ DIVORCED ☐ WIDOW ☐

MARRIED ☐ SEPARATED ☐ WIDOWER ☐

Address _____ Apt. # _____

City _____ State _____ Zip _____

Telephone _____ Cell Phone _____

Date of Birth _____ Age _____ Sex _____

Social Security # _____ Email _____

Employed By _____ Occupation _____ Phone _____

If Student / School Name _____

Name of Spouse / Parent _____

Employed By _____ Occupation _____ Phone _____

Person responsible for payment of the account / Insurance Subscriber:

Name _____ DOB _____ Sex _____

Subscriber Social Security # _____

Address _____

_____

Phone (Home) _____ (Business) _____

Referred By _____

Your Dentist _____ Physician _____

Has any other family member been seen in this office? _____

Names _____

Purpose of Visit _____

Insurance Company _____ Phone _____

Group # _____ ID # _____

I authorize Steve L. Koo, DDS, William D. Shepard, DDS, MD, or their employees to release and obtain information from my insurance carrier or other entities to obtain payment.

X _____

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MEDICAL QUESTIONNAIRE

(1) Have you been a patient in a hospital in the past two (2) years? If so, for what were you hospitalized? Yes ○ No ○

_____

_____

(2) Are you now – or have you been – under the care of a physician (including a psychiatrist) during the past two (2) years? Yes ○ No ○
If so, for what were you treated? (Check all that apply)

☐Stroke	☐High blood pressure	☐Bleeding disorders	☐ AIDS
☐Seizures	☐Rheumatic fever	☐Anemia	☐ Arthritis
☐Anxiety	☐Asthma	☐Hepatitis (yellow jaundice)	☐ X-ray
☐Depression	☐COPD	☐Diabetes	treatment
☐Glaucoma	☐Pneumonia	☐Thyroid disease	
☐Heart trouble	☐Stomach ulcers	☐Tuberculosis	
☐Congestive heart failure	☐Kidney or bladder trouble	☐Syphilis or venereal disease	

Other: _____

(3) List medicines/drugs you have taken during the past year and for what condition (include amount and frequency):

_____

_____

(4) Have you ever taken a steroid (e.g., cortisone) or a hormone medication? _____ Yes ○ No ○

(5) Have you had any surgical procedures in the past? _____ Yes ○ No ○

_____

(6) Do you have a personal or family history of an adverse reaction to anesthesia? If so, describe: _____ Yes ○ No ○

_____

(7) Have you ever had a reaction during – or following – dental treatment or oral surgery? Describe: _____ Yes ○ No ○

_____

(8) Do you have any implants in your body (e.g., hip, knee, heart valve, pacemaker)? _____ Yes ○ No ○

(9) Have you had a reaction to any medicine? Please list allergies: _____ Yes ○ No ○

_____

(10) When you cut yourself, or have a tooth extracted, do you bleed so much you have to see a doctor? _____ Yes ○ No ○

(11) Do you faint easily? _____ Yes ○ No ○

(12) Do you get short of breath easily? _____ Yes ○ No ○

(13) Have you gained, or lost, more than fifteen (15) pounds recently? _____ Yes ○ No ○

(14) Do you smoke? How much? _____ Yes ○ No ○

(15) Do you drink? How much? _____ Yes ○ No ○

(16) Do you – or have you ever – used recreational drugs? Please list: _____ Yes ○ No ○

(17) Do you have any sores or growths in your mouth? _____ Yes ○ No ○

(18) Have you ever had any serious injuries to your face or jaws? _____ Yes ○ No ○

(19) Have you had temporomandibular joint disorder or dysfunction? _____ Yes ○ No ○

(20) Do you wear contact lenses? _____ Yes ○ No ○

(21) Do you have any disease, condition, or problem not listed above that you think we should know about? _____

_____ Yes ○ No ○

(22) Women: If you are using oral contraceptives, it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics, or certain other medications may have a harmful effect on your developing baby, especially during the first trimester.

(A) Are you pregnant? Yes ○ No ○

(B) Do you wish to have a pregnancy test? Yes ○ No ○

Pharmacy Name _____ Phone _____

Weight _____ Height _____ Age _____ Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A. PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____ Patient ID#: _____

I authorize the release of information to:

_____

Name of individual Relationship to patient Telephone

To discuss the following type of information:
□ Healthcare
□ Financial

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting the below address.

Rights to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Attestation: I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____
If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received a copy of Thomas M. Weil, D.D.S., Steve L. Koo, D.D.S., and William D. Shepard, D.D.S., M.D. 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
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency prevented us from obtaining acknowledgement
□ Other: _____

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NOTICE TO PATIENTS

Regarding Prescribed Medications

I understand that the practice of Oral and Maxillofacial Surgery is one that may require the use of narcotic medications and other medications that can cause drowsiness and temporary cognitive impairment. These side effects may make the operation of heavy machinery hazardous to myself and to others. I acknowledge the recommendation that I do not drive nor operate heavy machinery while taking narcotic or sedative medications.

Regarding Cancelled, Late Arrival, and No-Show Appointments

I understand that my inability to maintain my scheduled appointment results in disruption of the practice. Cancelling within twenty-four (24) hours or inability to appear at my scheduled time may result in a penalty to reschedule. This will not exceed a ten percent (10%) deposit of the fee due at the time of the examination or procedure. Furthermore, I understand that a late arrival may require rescheduling of the appointment, which may incur the same penalty as aforementioned.

_____
Please Print Name

_____
Signature

_____
Date

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PATIENT PHOTOGRAPHY RELEASE FORM

I, _____, grant Thomas M. Weil, D.D.S., Steve L. Koo, D.D.S., and William D. Shepard, D.D.S., M.D. and their practice permission to take and use photograph(s) and digital image(s) of me for the medical record. I further consent to the use of my photograph(s) and digital image(s) for the purpose of (please check and initial all that apply):

- ❑ Medical publications (scientific journals) _____
- ❑ Educational endeavors (e.g., teaching) _____
- ❑ Promotional materials (e.g., website) _____

This request and authorization applies to photography or digital images taken on _____ (today's date) and beyond. This authorization will not expire unless written revocation is provided (as detailed below).

I understand that once my photograph(s) or digital image(s) have been released, Drs. Thomas M. Weil, D.D.S., Steve L. Koo, D.D.S., and William D. Shepard, D.D.S., M.D. and their practice may no longer have control over them, and the federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me cancelling this authorization, which would not prohibit any release done prior to the date of cancellation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

_____
Please Print Name

_____
Signature

_____
Date