Palmetto Oral and Maxillofacial Surgeons, P.A.

Dr. F. Douglas Oliver
Dr. J. Michael Morgan, IV
Dr. Matthew T. Lee

Date ______________________________ (   ) OLIVER (   ) MORGAN (   ) LEE

Chart # _______________________ Referring Physician / Dentist ______________________________________

Have you been a patient in this office before? _____ Yes _____ No If so, when? ________________________

PATIENT INFORMATION

Name ____
First Middle Last

Home Address ____ City/Zip ____________________________

Home Ph. # _______________________ Work Ph. # _____________________ Cell Ph. # ____________________

Date of Birth _____________________ Sex: ___ Male ___ Female Marital Status: ___ Single ___ Married

Social Security # ____ Age _____________________

Patient Employed By ____ Occupation _________________________

Notify in case of emergency __________________________________ Home/Work Ph. ______________________

PARENT OR GUARDIAN SIGNING PAYMENT AGREEMENT

First Name: ________________________________ Last Name: ______________________ Middle Initial: _______

Address: ______________________________________ Address 2: ____________________________________

City, State, Zip: ____ Pager: __________________

Home Phone: _______________ Work Phone: _______________ Ext: ________ Cell: ____________________

Birth Date: _______________ Social Sec: __________________________ Drivers Lic: ______________________

Primary Insurance	***Secondary Insurance***
Medical ____	Medical ____
Dental ____	Dental ____
Policy Holder's Name ____________________________	Secondary Policy Holder's Name ____________________
Policy Holder's Employer _________________________	Secondary Policy Holder's Employer _________________
Relationship to Patient __________________________	Relationship to Patient __________________________
Birth Date ______________ SSN __________________	Birth Date _______________ SSN __________________
Address (if different from above) _________________	Address (if different from above) __________________
City/State/Zip __________________________________	City/State/Zip __________________________________
Medicare _______________________________________	Medicaid _______________________________________

I GIVE PALMETTO ORAL & MAXILLOFACIAL SURGEONS, P.A. PERMISSION TO RELEASE ANY INFORMATION RELATING TO MY CLAIM AND I ALSO ASSIGN INSURANCE PAYABLE TO THIS OFFICE.

SIGNATURE OF PATIENT OR PARENT ______________________________________

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: ____

(PHYSICIAN)

____

(ADDRESS)

____

(CITY) **(STATE)** **(ZIP CODE)**

I hereby request that my medical records be released to:

____

(PHYSICIAN)

____

(ADDRESS)

____

(CITY) **(STATE)** **(ZIP CODE)**

____

(DATE)

____

(PATIENT'S SIGNATURE)

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302 West Pine Street
Florence, South Carolina 29501
(843) 669-4231
www.palmettooralsurgery.com

Name: ______________________ Date: ____________ Chart #: ____________

Dentist: ______________________ Physician: ______________________

Who referred you to our office: ______________________

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? Yes No
2. Have you ever had a bad experience in surgery or dental office? Yes No
3. Have you been a patient in the hospital during the past 2 years? Yes No
4. Have you been under the care of a medical doctor in the past 2 years? Yes No
5. Have you taken Zometa (zoledronic acid) or Aredia (pamidronate) as part of cancer treatment? Yes No
6. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by Penicillin, Aspirin, Codeine or any drugs or medicine? Yes No
7. Have you ever had any excessive bleeding requiring special treatment? Yes No
8. Circle any of the following you have had or have at present:

AIDS	Emphysema	Mitralvalve Prolapse
Alcohol Abuse	Epilepsy or Seizures	Nervousness
Allergies or Hives	Fainting or Dizzy Spells	Pain in Jaw Joints
Anemia	Glaucoma	Psychiatric Treatment
Angina Pectoris	Hay Fever	Rheumatic Fever
Appetite Suppressants	Heart Disease or Attack	Rheumatism
Arthritis	Heart Failure	Scarlet Fever
Artificial Heart Valve	Heart Murmur	Sickle Cell Disease
Artificial Joint	Heart Pacemaker	Sinus Trouble
Asthma	Heart Surgery	Stroke
Blood Transfusion	Hemophilia	Thyroid Disease
Bronchitis	Hepatitis A (infectious)	Tobacco Use
Bruise Easily	Hepatitis B (serum)	Treatment of Osteoporosis
Chemotherapy (cancer, leukemia)	Hepatitis C	Tuberculosis (TB)
Cold Sores	Herpes	Ulcers
Congenital Heart Lesions	High Blood Pressure	Venereal Disease
Cortisone Medicine	HIV	X-Ray or Cobalt Treatment
Cough	Kidney Trouble	Yellow Jaundice
Diabetes	Liver Disease	
Drug Addiction	Lupus	

9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? Yes No
10. Do your ankles swell during the day? Yes No
11. Do you use more than 2 pillows to sleep? Yes No
12. Have you lost or gained more than 10 lbs. in the past year? Yes No
13. Do you ever wake up from sleep short of breath? Yes No
14. Are you on a special diet? Yes No
15. Has your medical doctor ever said you have cancer or a tumor? Yes No
16. Do you have any disease, problem or condition not listed? Yes No
17. WOMEN: Are you pregnant now? Yes No

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

______________________ DATE

______________________ SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Consult for:

OPS:

MEDICATIONS:

ALLERGIES:

Age ____________________________

BP ____________________________

Pulse ____________________________

Temp. ____________________________

Weight ____________________________

Antibiotic ____________________________

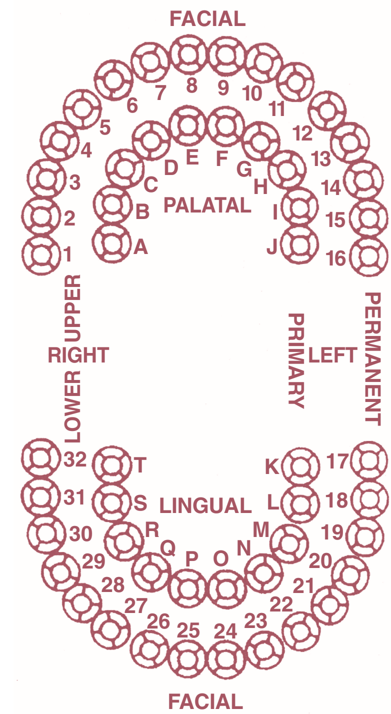
Valium ____________________________

Vistaril ____________________________

Initial ____________________________

Latex: yes no

Food: yes no



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M ____

HAS AN APPOINTMENT

DATE ______________________________ AT ____________________

THIS TIME IS BEING RESERVED FOR YOU

SURGICAL APPOINTMENTS

DO:

1. TAKE YOUR REGULAR MEDICATIONS WITH A SIP OF WATER. (Except Diabetics, bring but do NOT take Insulin or oral hypoglycemic medications.)
2. Take preoperative medications 30 minutes prior to appointment time unless otherwise written.
3. Bring a responsible adult with you who can stay in the office during and after your surgery, drive you home, and be responsible for your care. (No one can receive care without the presence of a chaperone). A parent or guardian must accompany any child.
4. Presurgical cleanliness is important! Please bathe, shampoo, and brush your teeth. Wear loose, comfortable, short sleeved clothing.
5. Advise the office if you develop fever, bad cough, flu or cold prior to your surgery.
6. Allow extra travel time so you will not be rushed or late for your time of arrival.
7. Anticipate your surgical, postoperative recovery, and instructional time to be 3 hours.
8. Do verify your insurance company benefits before your appointment. We cannot be responsible for insurance company decisions.

DO NOT:

1. DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE SURGERY.
2. Do not wear jewelry, tongue rings, make-up, nail polish, or false finger nails.
3. Please no perfume (several staff members are highly allergic).
4. Do not smoke before surgery.
5. Do not wear contact lenses.
6. It is best not to bring children.

Instructions: ____

____

____

____

____

Surgical Expense/Deposit ____________________

Palmetto Oral and Maxillofacial Surgeons, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: ____

Social Security Number: ____

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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

Please check all that apply:

________ I consent to Palmetto Oral & Maxillofacial Surgeons calling me at home or other designated location and leaving a message on voice mail or in person in reference to any items that assist in the treatment, payment and healthcare operations. This includes appointment reminders, insurance related communications and any communications regarding my personal clinical care such as diagnostic and laboratory test results.

________ I consent to receiving mail at home or other designated location items that assist in carrying out treatment, payment and healthcare operations such as appointment cards and patient statements.

________ I consent to allow Palmetto Oral & Maxillofacial Surgeons to communicate protected health information to the following individuals to assist in the provision of my personal care:

Name: ____ Relation: ____

Name: ____ Relation: ____

Name: ____ Relation: ____

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: ____

Relationship to Patient: ____

Palmetto Oral and Maxillofacial Surgeons, P.A.

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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

____

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