CARBON ORAL SURGERY ASSOCIATES, P.C.

FRANK L. HOFFMAN, D.M.D.
DIPLOMATE AMERICAN BOARD
ORAL AND MAXILLOFACIAL SURGERY

1001 MAHONING STREET
LEHIGHTON, PA 18235
610-377-1942

PATIENT INFORMATION: CONFIDENTIAL

DATE ____________________

NAME ____

ADDRESS ____________________ CITY ______________ STATE ______ ZIP __________

HOME PHONE NUMBER ______________ CELL # ______________ MARITAL STATUS ________

BIRTHDATE ______________ AGE ______ SOCIAL SECURITY # ______________

PATIENT'S OR PARENT'S EMPLOYER ____________________ WORK PHONE ______________

BUSINESS ADDRESS ____________________ CITY ______________ STATE ______ ZIP ________

OCCUPATION ____

SPOUSE OR PARENT'S NAME ____

SPOUSE OR PARENT'S EMPLOYER ____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE ______________ CITY ________ STATE ____

FAMILY DENTIST ____

FAMILY PHYSICIAN ____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________ RELATIONSHIP TO PATIENT ______________

INSURANCE INFORMATION

DENTAL INSURANCE:

COMPANY NAME ____

GROUP NUMBER ____

AGREEMENT NUMBER ____

INSURED NAME ____

MEDICAL INSURANCE:

COMPANY NAME ____

GROUP NUMBER ____

AGREEMENT NUMBER ____

INSURED NAME ____

RELATIONSHIP TO PATIENT ____________________ BIRTHDATE OF SUBSCRIBER ______________

PLEASE CONTINUE TO NEXT PAGE

MEDICAL HISTORY

Patient Name ______________________________

Whom may we thank for referring you? ______________________________

Why are you visiting us today? ______________________________

1. Date of last physical examination? ______________________________
2. Are you now under the care of a physician? ______________________________
3. List any operations you have had and the approximate date: ______________________________
4. List any serious medical illness which required hospitalization and the approximate date: ______________________________
5. Do you smoke? Yes / No Amount: ______________________________
6. Do you drink alcohol? Yes / No Amount: ______________________________
7. Please list any drug, food or other thing to which you are allergic: ______________________________
8. Please list any medications (and dosage) you are taking now: ______________________________
9. Are you pregnant? Yes / No
10. Have you ever received radiation treatment? Yes / No
11. Please CIRCLE any of the following which you have or have had:

Heart or blood vessel problems	Shortness of breath
Rheumatic fever	Trouble breathing/Emphysema
Congenital heart disease	Asthma
Heart Murmur	Fainting spells
Chest pain/Angina	Seizures

12. Pharmacy Choice: ______________________________

Please CIRCLE any of the following which you have or have had:

- Heart attack
- Heart failure
- High blood pressure
- Stroke
- Vein Problems
- Ulcers
- Stomach trouble
- Kidney problems
- Bladder problems
- Problems with nerves
- Unusual fear of dental treatment
- Problems with local anesthesia
- Gland problems (thyroid, pancreas, adrenal)
- Hayfever
- Diabetes
- Hepatitis
- Yellow jaundice
- Liver disease
- Arthritis
- Painful joints
- Anemia or other blood disorders
- Any bleeding problems
- Venereal disease
- AIDS/HIV infection
- Psychiatric treatment
- Any tumor surgery
- Radiation treatment
- Any infectious diseases
- Joint replacement/implant
- Jaw joint/TMJ problems

Please CIRCLE any of the following conditions which other family members have:

A bleeding problem   Diabetes   High blood pressure

Is there anything else in your medical or dental history that we should be aware of?   Yes / No

If yes, please provide additional information ____________________________________

____

____

____

SIGNATURE:______________________________ **DATE:** ______________

Patients with insurance — need signature on file:

AUTHORIZATION TO RELEASE INFORMATION The above answers are true and correct to the best of my knowledge. A photostat of this authorization shall be as valid as the original. I authorize the release of any dental information necessary to process this claim.	SIGNED (PATIENT OR PARENT IF MINOR) DATE
AUTHORIZATION TO PAY BENEFITS TO DENTIST I hereby authorize payment directly to the below named Dentist of the Group Benefits otherwise payable to me, provided that the required tax ID number has been furnished.	SIGNED (INSURED PERSON) DATE

HISTORY UPDATE

Date	Changes

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Summary of Privacy Practices/HIPAA

This notice describes how medical information about you may be used and disclosed.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information?

Treatment: Communications between and disclosures to referring doctors and specialists, hospitals and other healthcare facilities, and other providers for furnishing treatment.

Payment: Typical payment related activities such as verification of coverage, precertification, referrals, claim processing and the like.

Health care operations: Certain administrative and management activities such as compliance monitoring, quality improvement and business planning for the Practice.

You have certain rights regarding the information we maintain about you. You have the right to inspect and copy; right to amend; right to request restrictions; right to a paper copy of this notice and right to request confidential communications.

Please indicate the individuals whom we may discuss your patient information with if we must call your home:

- ❑ Self only
- ❑ Spouse
- ❑ Other: specify ____

This consent was signed by: ______________________________

Relationship to Patient: ______________________________
(if other than patient)

Date: __________________