DR. BRANDON GREER DMD MD
Oral Surgery and Dental Implants

Date: _____/_____/_____ ACCOUNT:_____

Patient Name: _____ Date of Birth: _____/_____/_____ Age: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____/_____/_____Cell: _____/_____/_____ Work : _____/_____/_____

Email Address: _____SS# _____/_____/_____

Drivers License :_____Male_____ Female _____Employer: _____

Spouse/Parent if minor: _____ Date of Birth: _____/_____/_____

SS# _____/_____/_____ Drivers License:_____

Address :_____ City: _____ State: _____ Zip: _____

Phone: _____/_____/_____ Employer: _____Work: _____/_____/_____

Emergency Contact: _____ Relationship: _____ Phone: _____/_____/_____

PRIMARY INSURANCE INFORMATION

Even though we will make a copy of your card, there is information on card that we do not have-please complete the following

Policyholder: _____ Relationship: PARENT OR LEGAL GUARDIAN

Dental Insurance: _____ ID# _____ Group# _____

Insurance Address :_____ City: _____ State: _____ Zip: _____

Phone: _____/_____/_____ DOB: _____/_____/_____ SS#: _____/_____/_____

Employer: _____

SECONDARY INSURANCE INFORMATION

Even though we will make a copy of your card, there is information on card that we do not have-please complete the following

Policyholder: _____ Relationship: PARENT OR OTHER:_____

Dental Insurance: _____ ID# _____ Group# _____

Insurance Address :_____ City: _____ State: _____ Zip: _____

Phone: _____/_____/_____ DOB: _____/_____/_____ SS#: _____/_____/_____

Employer: _____

Patient's Dentist: _____ Referring Dentist: _____

PLEASE LIST ANY FAMILY MEMBERS OR FRIENDS THAT WE MAY COMMUNICATION WITH REGARDING YOUR INFORMATION

Name: _____ Relationship: _____Phone: _____/_____/_____

Name: _____ Relationship: _____Phone: _____/_____/_____

PATIENT'S HEALTH HISTORY

	YES	NO
Has there been any change in your general health in the last year?		
Are you under the care of a physician?		
If so, Doctor Name: _____ Phone: _____/_____/_____		
If so, for what are you being treated: _____Last Visit: _____/_____/_____		
Have you had any illness, operation or been hospitalized in the past 5 years?		
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around the mouth?		
If so, describe where: _____		
Do you have a prosthetic joint? If so, where? _____		
Do you have a vascular graft? If so, where? _____		
Do you have a prosthetic heart valve?		
Is there any condition concerning your health that Dr. Brandon Greer should be told?		
Do you wish to speak with Dr. Brandon Greer privately about anything?		

	YES	NO
Rheumatic fever		
Damaged heart valves/mitral valve prolapse		
Heart Murmur		
High Blood Pressure		
Low Blood Pressure		
Heart Attack		
Irregular heartbeat		
Cardiac pacemaker		
Heart surgery		
Bronchitis, chronic cough		
Asthma		
Hayfever/Sinus problems		
Tuberculosis		
Bipolar Disorder, ADHD or ADD (circle)		
Emphysema		
Difficult breathing/other lung trouble		
Sleep Apnea YES/NO -- CPAP Machine --YES/NO		
History of taking Fosamax or related meds		
Pregnant? YES/ NO IF so, Delivery ___/___/___		
Weight_____		

	YES	NO
Blood disorder such as anemia		
Bleeding tendency (abnormal bleeding)		
Jaundice, Hepatitis or liver disease		
Convulsions, epilepsy		
Stroke		
Thyroid trouble		
Kidney Trouble		
Are you on dialysis?		
Diabetic		
History of drug abuse?		
History of alcohol abuse?		
Xray treatment/chemotherapy		
Eye disease/glaucoma		
Swollen ankles, arthritis or joint disease		
Pain & clicking of jaws when eating		
Malignant hyperthermia		
Problems with immune system		
Tested positive for HIV or AIDS		
Do you smoke? # Packs of day _____		

MEDICATION

Please list any medications you are taking: (If you have a list of them, we will be happy to make a copy instead)

ARE YOU ALLEGIC OR HAD A REACTION TO:

	YES	NO
Local Anesthesia		
Penicillin		
Sodium pentothal, Valium or tranquilizers		
Aspirin		

	YES	NO
Codeine or other narcotics		
Eggs		
Iodine		
Latex		

IS THERE A FAMILY HISTORY OF:

	YES	NO
Cancer		
Diabetes		

	YES	NO
Heart Disease		
Anesthetic Problems		

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DR. BRANDON GREER. I UNDERSTAND I AM FINANICALLY RESPONSIBLE FOR ANY BALANCE. I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED FOR THIS CLAIM AND MY PROCEDURES.

Name (Printed) _____

Signature: _____ **Date:** _____/_____/_____

Pharmacy Information

Patient Name: _____

Patient DOB: _____/_____/_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy City: _____

Pharmacy State: _____

Pharmacy Zip Code: _____

Pharmacy Phone Number: _____/_____/_____

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ACKNOWLEDGMENT AND CONSENT FOR TREATMENT USING SCHEDULE II AND SCHEDULE lll CONTROLLED NARCOTIC MEDICATIONS

I understand and have been explained that my condition as examined and evaluated by Dr. Brandon Greer may require the issuance of a Schedule ll or a lll controlled Narcotic.

This medication may have side effects that include but are not limited to constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate automobile or other machinery while using these medications and I may be impaired during all activities, including work.

I further understand that Kentucky House Bill 1 restricts the amount of Schedule ll and lll narcotic medication issued and when such medication can be filled.

I acknowledge that should additional medication be necessary, I will be required to return to Dr. Brandon Greer office for further evaluation before more Schedule ll or lll narcotic medication is issued or refilled more than once; at which time a fee may be required for such service.

I also understand that this office will be required under Kentucky House Bill 1 to investigate and review prior Schedule ll or lll narcotic medication received before issuing such medication.

FOR FEMALE PATIENTS ONLY:

TO THE BEST OF MY KNOWLEDGE_____ I AM PREGNANT _____ I AM NOT PREGNANT

I understand that I must tell Dr. Brandon Greer immediately if I am pregnant, as the medications prescribed could have an adverse effect upon me and/or my unborn child.

PATIENT, PARENT, LEGAL GUARDIAN, OR HEALTH CARE SURROGATE

Signature: _____ Date: _____/_____/_____

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SUMMARY OF PRIVACY PRACTICES

Due to federal legislation passed by Congress in 1996 entitled the Health Insurance Portability and Accountability Act (HIPPA) all healthcare providers and related facilities are required by law to abide the guidelines for patient privacy and for the confidentiality and security of all protected Health Information. "Protected health information" refers to any written or electronically stored data that contains demographic, treatment, past medical history, and/or any other information that is created or received by your healthcare provider. This includes all physical records as well as information stored in electronic databases.

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length notice is posted within the facility, and a copy will be made available to you. This notice is effective immediately.

This summary of Privacy Practices will include the following:

1. The ways in which the provider will use and disclose the patient's personal health information.
2. The patient's rights under HIPPA.
3. The provider's responsibilities under HIPPA.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your healthcare provider can use or disclose your protected health information for the purposed of providing treatment, obtaining payment for treatment, conducting health operations, or for those instances required by law. We may disclose our information in the instance that it is required to coordinate or manage your healthcare and any related services. For instance, we may disclose your information to other physicians who may be treating you or consulting your physician with respect to your healthcare and treatment.

Your protected health information will be used to obtain payment for the services that we provide. This includes communication with your health insurance provider to obtain eligibility and a description of plan benefits, and we may also need to disclose your information to the insurance carrier in the instances of obtaining a prior authorization, demonstrating medical necessity, etc.

The federal privacy rules under HIPPA allow your healthcare provider to use and disclose your information in instances beyond treatment, payment and operations and do not require consent to do so in certain situations, such as when required by federal, state and local law; to report abuse and neglect, or when there are risks to public health and safety.

PATIENT RIGHTS

HIPPA allows you, the patient, and various rights in regard to your protected health information. you have the right to inspect and copy your health information unless in a circumstance prohibited by law. You will be required to submit this request in writing, and you may be charged a fee to cover the costs of copying, mailing, etc. you have the right to request restrictions on uses and disclosures of your health information. You have the right to request that certain aspects of your information may not be used for the purposes of treatment or payment and the right to request that we do not disclose our information to family members or friends involved in your care. Furthermore, HIPPA provides you the right to an accounting of all disclosures of your health information. Last, you have the right to make amendments to your information if any element of that information changes. All such request to exercise such rights must be submitted in writing to Dr. Brandon Greer Oral Surgery at 270-599-0334. In the event that your request for access or restriction is denied, you will be given a written notice and you have the opportunity to appeal the decision.

You also have the right to submit formal complaints, if you think your privacy have been violated. You may submit these to Dr. Brandon Greer Oral Surgery or the Secretary of Health and Human Services.

PROVIDER'S RESPONISBILITY

We, as the provider, have the responsibility to make you aware of HIPPA and how it relates to you and your treatment. We are required to supply you with a written copy of the Summary of Privacy Practices if you so desire and to make the full-length version of the Notice of Privacy Practices available to you. We also have the responsibility to accept formal complaints and may not retaliate against or attempt to dissuade you in that instance. HIPPA requires that we maintain the privacy and integrity of your protected health information. We must abide by the terms of this abbreviated notice and the terms of the entire notice. We, however, reserve the right to make changes or amendments to the notice, but we will make revisions known to us as soon as they are in place and provided you with a written copy of the revised notice.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have read and understand the terms of the Privacy Practices of Dr. Brandon Greer and have had the opportunity to ask questions about the use and disclosure of my health information. Furthermore, I understand I may request a copy of the Summary of Privacy Practices if I so desire. I hereby, knowingly and voluntarily, authorize this office to use or disclose my health information in the manner described above.

Name (PRINTED): _____ Signature: _____Date: _____/_____/_____

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Cancellation/No show Policy

We understand that you may need to reschedule an appointment. When you are scheduled for your appointment, we are reserving that space for you to be seen by the doctor. In order to provide the best service here at Greer Oral Surgery, we please ask that if you do need to reschedule an appointment that you call as soon as possible or at least 24 hours in advance.

*If you have no showed for your appointment, we will require a **non-refundable** deposit to be made prior to re-scheduling.

Financial Policy

Please understand payment is due day of procedure. Unfortunately, we do not offer any payment plans in the office at this time. Forms of payment we accept are: Cash, Check, Card, Care Credit and HFD Financing. Any returned checks **WILL** have a fee of **$50** added onto your current balance.

We thank you for your trust in treating you here at Greer Oral Surgery.

Patient Signature_____

Date_____