LAKESHORE ORAL & MAXILLOFACIAL SURGERY
HEALTH HISTORY QUESTIONAIRE

Patient's Name **Date of Birth** **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 or Dizziness ..... 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. Osteoporosis ..... Y N
   - O. 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
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. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - J. Please list any and all prescription medications, diet drugs, weight loss drugs, energy boosters, over-the-counter mediations, holistic remedies, vitamins, minerals, or recreational drugs: _____

     _____

     _____
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. Are you nursing? ..... Y N
    - C. **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 ready my Health History dated _____ and confirm that it adequately states past and present conditions.

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

LAKESHORE ORAL & MAXILLOFACIAL SURGERY

NEW PATIENT INFORMATION

Welcome to our surgical practice. We are glad you have entrusted your needs to our treatment team. Please complete this form to the best of your ability in an effort to provide you with comprehensive care. If you have any questions please ask any one our patient care coordinators who welcome the opportunity to assist. All information provided will be kept strictly confidential and according to the current Health Information Privacy Act guidelines. Your privacy and confidentiality are very important to us.

Patient Information:

Name: _____ Date: _____

Age: _____ Date of Birth: _____/_____/_____ Occupation: _____ Marital Status: _____

Social Security #_____ Driver's License Number: _____ State: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Name of Spouse or Parent if patient is a minor: _____

Responsible Party:

Name: _____ Date: _____

Age: _____ Date of Birth: _____/_____/_____ Occupation: _____ Marital Status: _____

Social Security #_____ Driver's License Number: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Employer & Address_____ City: _____ Zip: _____

Work Phone: _____

Who referred you to our office? _____ Reason: _____

Name of Family Dentist: _____ Last visit: _____ City: _____ Phone: _____

Name of Primary Care Physician: _____Last visit: _____ City: _____ Phone: _____

Insurance Information:

Primary Dental Insurance Company: _____ Group#:_____ ID: _____

Insured's Name: _____ Relationship _____ PPO HMO Don't know (Circle one)

D.O.B.:_____

Insurance address: _____ Insurance Phone number: _____

Please read carefully and initial or sign where indicated.

I herby authorize Peter A. Krakowiak DMD APDC and/or Lakeshore Oral & Maxillofacial Surgery and any of its doctor's and/orstaff to furnish information to dental/ medical insurance carriers concerning my treatment and hereby assign directly to Peter A. Krakowiak DMD APDC all payments for dental and surgical services rendered. This assignment will be required to allow the office to bill and receive payments for my care from any third party and will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I understand that it is my sole responsibility to understand my own insurance benefits and coverage. I understand and agree that payments are due on the day services are rendered. I hereby authorize Lakeshore Oral & Maxillofacial Surgery/Peter A. Krakowiak DMD APDC to release all information necessary to gain reimbursement. If the insurance fails to pay for the charges in 60 days after delivery of care I will reimburse the office directly and pursue my claim personally with my insurance carrier. I understand that any unpaid fees are subject to 18% annual interest charges, collection costs, and any additional financing costs.

I understand that I am financially responsible for all charges whether or not paid by my Insurance/Dental Plan. Initial_____

I hereby acknowledge that I have received a copy of Lakeshore Oral & Maxillofacial Surgery's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. Initial_____

I consent to taking any necessary records, radiographs, and photographs of my case and permit Dr. Krakowiak and/or Dr. Nielsen to use these materials in professional communications, publications, and educational presentations. Initial_____

I understand and agree to pay a $100.00 surgical booking fee prior to scheduling a surgical appointment. I fully understand if the appointment is missed without a 36 hour notice this fee is NON-refundable. Initial_____

I understand due to the nature of surgical therapy, differences in human constitution and response it is no way possible to warrant the outcome of any medical, surgical, dental service, or therapy. I give Dr. Krakowiak and/or Dr. Nielsen permission to perform any and all necessary treatment as he feels appropriate in the course of delivery of my surgical care. I am aware that all surgical procedures and therapy have inherent risks and complications and I will ask all questions to ensure my understanding of the treatment before commencing with any therapy.

Patient's Signature: _____ Responsible Party's Signature: _____ Date: _____

LAKESHORE ORAL & MAXILLOFACIAL SURGERY
PETER A. KRAKOWIAK DMD APDC

Notice of Billing Policy

Dear Patient,

Welcome to our practice, the entire treatment team at Lakeshore Oral & Maxillofacial Surgery is here to support you for the duration of your time with us and we truly appreciate the opportunity to work with you in achieving optimal oral health. It is our goal to provide you with excellence in clinical care and customer service. With that, our office will bill your dental insurance in an effort to maximize your benefits for the specialized care we provide. We cannot, however, guarantee that your insurance company will cover all or a portion of your treatment. Please note that all fees associated with your treatment are your responsibility in the event your insurance does not cover the cost of treatment. Your insurance company has 60 days to pay a claim on your behalf. If there is a remaining balance on your account you will be notified accordingly and payment is due at that time for all unpaid claims. If you have any questions regarding our policies or procedures please do not hesitate to contact our billing administrator. In addition, if you have general questions regarding your insurance coverage any one of our qualified patient care coordinators welcome the opportunity to help.

Sincerely,
Treatment Care Coordinators
Lakeshore Oral & Maxillofacial Surgery

Authorization to Release Health Care Information

I _____request and authorize the above listed doctor and practice to release health care information of the patient named above to:

1. Name: _____Relationship:_____

Phone Number: _____

2. Name: _____Relationship:_____

Phone Number: _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called “Revocation of Authorization for Use and Disclosure of Health Care Information” or

- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____
Signature of patient or patient’s authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

LAKESHORE ORAL & MAXILLOFACIAL SURGERY

Peter Krakowiak DMD APDC

DR. KRAKOWIAK, DR. NIELSEN, AND ASSOCIATES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
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 this 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 October 15, 2006, 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, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while 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 your 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 your 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 authorized 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 practicably 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 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* ***$0.50 for each page****,* ***$15.00*** *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 the 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 accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our 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 locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments 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.

Electronic 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 also 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: Lakeshore Oral & Maxillofacial Surgery Administrator

Telephone: (951) 471-3334 Fax: (951) 471-3347

E-mail: LakeshoreOralSurgery@yahoo.com

Address: 265 San Jacinto River Rd., Lake Elsinore, CA, 92530

Patient's Signature: _____ **Date:** _____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

L A K E S H O R E O R A L & M A X I L L O F A C I A L S U R G E R Y
PETER KRAKOWIAK DMD FRCD(C) & ASSOCIATES

2 6 5 S A N J A C I N T O R I V E R R D # 1 0 1
L A K E E L S I N O R E , C A 9 2 5 3 0
P H O N E 9 5 1 - 4 7 1 - 3 3 3 4 F A X 9 5 1 - 4 7 1 - 3 3 4 7

Medicare
Private Contract

By signing this contract I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare of its agents for services provided by Lakeshore Oral and Maxillofacial Surgery, Dr. Peter Krakowiak, even if such services would otherwise be covered.

I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Lakeshore Oral and Maxillofacial Surgery, Dr. Peter Krakowiak and I understand that no claims will be submitted to Medicare and no Medicare reimbursement will be provided for these services.

I understand that there are no limits specified by Medicare as to the amounts that may be charged by the oral and maxillofacial surgeon for services provided.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out.

I understand that Lakeshore Oral and Maxillofacial Surgery is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

This contract is effective on _____ and it will expire on _____.
(date) **(date)**

Patient Name: _____

Patient's Signature: _____

Oral and Maxillofacial Surgeon's Signature: _____
Dr. Peter Krakowiak