TREASURE VALLEY
ORAL & FACIAL SURGERY

Cole W. Anderson, DMD, MS

PATIENT INFORMATION

Patient's last name: First: Middle:		Birth date:	Driver Name & Phone #:	
Home Phone #:	Work #:	Cell #:	Age:	Sex: ☐ Male ☐ Female
Street address:		SS #:	Referring Dentist:	
City:	State:	Zip Code:	Personal Physician:	
Emergency Contact person:	Relationship to patient:	Home Phone #:	Work or Cell #:	

INSURANCE INFORMATION

PERSON with Financial Responsibility:	Address:	Birth Date:	Phone #'s:	
Company Name: (if work-related ins.)	Company Address and Phone #:		Relationship of Patient to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	
PRIMARY Insurance Co: ☐ Dental or ☐ Medical	Subscriber's Name:	Policy#:	Group #	Birth Date:
SECONDARY Insurance Co: ☐ Dental or ☐ Medical	Subscriber's Name:	Policy#:	Group #	Birth Date:

HEALTH HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree:

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Trouble, Heart Murmur	☐	☐	Cancer	☐	☐	Previous Surgeries
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Prosthetic Joints
☐	☐	Chest Pains or Shortness of breath	☐	☐	Thyroid	☐	☐	Osteoporosis
☐	☐	Excessive Bleeding, Bleeding Disorder	☐	☐	Glaucoma	☐	☐	Ever taken Actonel?
☐	☐	Asthma or Lung Disease	☐	☐	Kidney or Liver Problems	☐	☐	Ever taken Zometa?
☐	☐	Smoke or Use Smokeless Tobacco	☐	☐	Hepatitis C or HIV	☐	☐	Allergic to:
☐	☐	Stroke or Seizure	☐	☐	Possible Pregnancy			

Current Medications: (Please list here or on back of this page.)

____

____

INSURANCE ASSIGNMENT AND CONSENTS

- I give consent for clinical photographs for education, training, and patient record purposes? ☐ YES ☐ NO
- I authorize my insurance benefits be paid directly to the physican. I understand that I am financially responsible for any balance. I also authorize Treasure Valley Oral & Facial Surgery or insurance company to release any information required to process my claims.

______________________________ ______________

Patient/Guardian Signature *Date*

Notice of Practice Privacy

This notice describes how medical information about you may be used and disclosed. It also explains how to obtain access to this information. Please review it carefully.
The Health Information Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of the health information and how we may use and disclose you health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.
Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers of specialists involved in the continuation of your care.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reviews. For example, we disclose treatment information when billing insurance for your treatment.
Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.
Unless you request otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending postcards and/or leaving messages at home/work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to request to receive confidential communications of protected health information from us by alternative or at alternative locations. The right to access, inspect and copy your protected health information. You have the right to request an amendment to your protected health information. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of **April 15, 2003** and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revises Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services Office of
Civil Rights, in the event you feel you privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact: For more information about HIPAA or to file a complaint:

Dr. Cole W. Anderson
1000 N. Curtis Rd., Suite 103
Boise, Idaho 83706
(208)343-0909

US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(877)696-6775 (toll free)

I, ______________________________ have read the Notice of Privacy Practices. I understand the circumstances in which my Protected Health Information may be used by this practice and its agents. I agree to the conditions discussed above. Other family members which are included in this agreement re: ______________________

Patient signature: ______________________________ Date: ______________________