Oral & Maxillofacial Surgery
Patient Information
(Please Print)

Patient's Name:_____ Date:_____

Is this your legal name? yes / no If not, what is your legal name:_____

Home Phone #: _____ Cell Phone #: _____

Email: _____ How do you prefer we contact you? ___ Cell ____ Home Phone ____ Email

Home Address: _____
Street Apt City State Zip

Birth Date (mm/dd/yyyy):_____ SS#:_____ Gender: _____Race: _____

Language Preference: _____ License: State_____#_____

Marital Status:_____ Employed by:_____ Work Phone: _____

Work Address:_____
Street Suite City State Zip

In Case of an Emergency : Name: _____ Phone: _____ Relationship: _____
(other than members of household)

Guarantor Information

Name **(if different):**_____Birth Date:_____ Relationship to patient:_____

SS#:_____ License: State_____#_____ Sex:_____ Marital Status:_____

Address:_____ Home Phone:_____

Cell Phone:_____ E-mail Address_____ Work Phone_____

Work Name:_____ Address:_____

INSURANCE INFORMATION: PLEASE PRESENT INSURANCE CARD FOR COPIES

Subscriber's name(**if different):**_____Subscriber Birth Date: _____

SS#:_____ Phone:_____ Relation:_____

Ins Company:_____ Ins Phone #:_____Group#:_____

InsAddress:_____
Street City State Zip

(If there is secondary Ins)

Subscriber's name**(if different**):_____ Subscriber Birth Date:_____

SS#_____ Phone:_____ Relation: _____

Ins Company:_____ Ins Phone #:_____ Group#:_____

Ins Address:_____
Street City State Zip

Oral and Maxillofacial Surgery
MEDICAL INFORMATION

Name_____

Age_____Sex_____Weight_____Height_____

Physician: _____Last Physical Exam: _____

Referred By: _____Dentist: _____

Have you had any of the following:

	Yes	No		Yes	No
Heart Disease	___	___	**Anemia**	___	___
Asthma	___	___	**Gastric Ulcer**	___	___
Hepatitis	___	___	**Cancer**	___	___
Nervous Disorder	___	___	**Heart Murmur**	___	___
Bleeding Tendency	___	___	**Seizure Disorder**	___	___
Lung Disease	___	___	**Blood Transfusion**	___	___
Joint Replacement	___	___	**Food/Drug Allergies**	___	___
Arthritis	___	___	**High Blood Pressure**	___	___
Kidney Disease	___	___	**Glaucoma**	___	___
Liver Disease	___	___	**Diabetes**	___	___
Thyroid Disease	___	___			

LIST ALL FOOD OR DRUG ALLERGIES:

_____

List all current medications taking:

_____

Have you been hospitalized in the last two years? Yes____No____List any major surgical procedures:

_____

Have you taken cortisone in the last year? Yes____No____ Are you pregnant? Yes____No____

Have you been told by a Doctor that you have a weakened immune system or susceptible to infection? Yes____No____

Please provide any additional information you feel may be important about your health:

_____

I certify that I have read and understand the information I provided on this form and answered them all truthfully and to the best of my ability. I understand that if any change occurs in my health, I must report it to the office as soon as possible. I will not hold the dentist or his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature_____ Date_____

Reviewing Doctor _____ Date_____

RANDALL M. WILK, DDS, MD, PhD

HIPPA PRIVACY PRACTICES

How We Collect Information About You: Randall M. Wilk, DDS, MD, PhD and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between Randall M. Wilk, DDS, MD, PhD and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Randall M. Wilk, DDS, MD, PhD. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* (*upon request)* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

_____ Accepted _____ Denied

Signature_____

Date: _____

DR. RANDALL M. WILK, D.D.S., Ph.D., M.D.

The primary goal of our practice is to provide you and your families with the highest quality oral & maxillofacial surgery care in a safe and comfortable environment. Our professional staff is dedicated to health or well being. Please feel free to ask the doctor or staff questions concerning you treatment at any time.

FINANCIAL POLICY

The patient or guarantor is financially responsible for all services rendered whether or not you have insurance.

Payment Options:

1. **Cash-includes money orders and personal checks**
2. **Visa/Mastercard/Discover/AX/Care Credit-we accept credit cards as payment for treatment**

Insurance/PPO: The total surgery fee is required at the time of service unless pre-authorized in writing by your insurance company. An insurance claim form will be given to you to submit for reimbursement. The clerical staff will be happy to assist you as necessary and the doctor and staff will act as your advocates when required. All claims are subject to plan terms and provisions. This means that the benefit payable is determined according to the insurer's eligibility, the limitations, exclusions and conditions of the plan.

Pre-authorized Insurance Claims: Balance due at the time of surgery.

DMO'S and HMO'S: Payment based upon State and Federal regulations.

I have reviewed the above financial statement and understand the terms and conditions.

Patient or Authorized Person's Signature_____ Date_____

Insurance Assignment

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Patient or Authorized Person's Signature_____ Date_____

Authority to Release Information

Permission is hereby granted to Dr. Randall M. Wilk, D.D.S., Ph.D., M.D. to release information concerning my physical condition to my insurance company representatives, attorney, physician or dentist. (If your treatment involves an accident or consultation with insurance company representative or your attorney.) I hereby acknowledge that I had he opportunity to read the Privacy practices for this office and have been given and opportunity to ask any questions I may have regarding this Notice.

Patient or Authorized Person's Signature_____ Date_____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF

PROTECTED HEALTH INFORMATION

Information to be used or Disclosed:

The information covered by this authorization includes:
My protected health information, physicians, messages, communications by telephone/fax/email. Etc.

Persons Authorized to Use or Disclose Information:
Information listed above will be used or disclosed by:

Randall M. Wilk, DDS,MD,PhD.
120 Meadowcrest St, Suite300
Gretna, LA 70056

Persons to Whom Information may be Disclosd:
Information described above may be disclosed to:

Spouse/Father/Mother/Other:

_____

Name of Person/Employer/Organization:

_____

Expiration Date of Authorization:
This authorization is effected as dated below unless revoked or terminated by the patients or the patient's Holder-Assignor-Parent-Guardian.

Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to
Randall M. Wilk,DDS,MD,PhD
You should contact our **Privacy/Compliance Officer** to terminate this authorization.

Potential for Re-Disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Name of Patient DOB

_____ _____
Signature of Patient Date

_____
Signature of Patient's Holder-Assignor-Parent-Guardian