MURPHY ORAL & MAXILLOFACIAL SURGERY

ARIC A. MURPHY, DDS, MD

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient my revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Patient Name: ____

May we leave a message with more detailed health and or financial information on your cell phone and or home phone? Yes No

May we discuss your medical procedure, health history and or financial information with any other member of your family? Yes No

If YES, please name the members allowed: ____

This Consent is signed by: ____
Name of Patient or Representative (PLEASE PRINT NAME)

Signature & Date: ____

Relationship to Patient if other than patient: ______________________________________

Practice Representative Signature (Witness): ____________________________________

__ Patient refused to sign.
__ Due to an emergency situation it was not possible to obtain an acknowledgement.
__ Other: ____

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Date: _______________

First Name___________________ MI___ Last Name______________________________

Gender: ◯ Female ◯ Male ◯ Other

Date of Birth _____/____/_______ Age______ SS#_______________________________

Primary Phone # _____________________ Email Address _______________________

Preferred Method of Contact ◯ Text ◯ Phone ◯ Email

Home Address____

City, State, Zip____

Referring Doctor / Dentist ____

Pharmacy (and location) ____

Emergency Contact (Name & Number) ________________________ Relationship: _______________

RESPONSIBLE PARTY FOR YOUR ACCOUNT ( ) Self ( ) Parents/Guardian ( ) Other

Parent/Guardian Name (First & Last) ____

Date of Birth _____/____/_______ SS# (required) _____________________________

Primary Phone # _____________________ Email Address ____________________________

Driver License Number: ____________________ Employer (Required) _______________________

Address_________________________________

DENTAL INSURANCE: **(Or a COPY of your insurance card)**

Insurance Company Name: ______________________________ Effective Date: ____________

Name of Insured Party: __________________________________

Member ID or SS #: ____________________________________

Insured Date of Birth: __________________________________

Group#____

If Requested –MEDICAL INSURANCE : **(Or COPY of card)**

Insurance Company Name: ______________________________

Member ID or SS #: ____________________________________

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ARIC A. MURPHY, DDS, MD

Name:________________________________ Date:________________________________

Date of Birth: _________________________ Sex: M / F Height:_________Weight: _____________

Your answers are for our records only and will be kept confidential.

Main Concern you would like addressed by the Doctor:____

1. Do you have any **Medical Problems**?.. Yes No
   If so please list: ____

2. Do you have any **Allergies to Medications (or egg products or soy products)**? .... Yes No
   If so, please list: ____
3. Do you have **Asthma**?.. Yes No
   If so, rate severity: mild/moderate/severe; If you use an inhaler please list medication:____________________
4. Do you **Smoke or VAPE**?.. Yes No
5. Have you had an **Artificial joint replacement** (knee, hip, shoulder, etc.)? .... Yes No
6. Are you **currently taking any Medications** (including vitamins or homeopathic medications)?........ Yes No
   If YES please list, and list dose if known:

____

____

   Have you ever taken **Bisphosphonates** for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? .... Yes No
7. Are you now under the care of a physician?.. Yes No
   If you know the name of your physician please list: ___________________________________
8. **Do you have any of the following diseases or problems**?
   a. Damaged heart valves, artificial valves or heart murmur .... Yes No
   b. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No
      1. Chest pain upon exertion?.. Yes No
      2. Shortness of breath after mild exercise? .... Yes No
      3. Do your ankles swell?.. Yes No
   c. Hay fever.. Yes No
   d. Fainting spells or seizures .... Yes No
   e. Diabetes (Type I / Type II) .... Yes No
   f. Hepatitis, jaundice or liver disease .... Yes No
   g. Thyroid problems.. Yes No
   h. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   i. Arthritis or painful, swollen joints including jaw joint (TMJ).. Yes No
   j. Osteoporosis .... Yes No
   k. Stomach ulcer or hyperacidity .... Yes No
   l. Kidney trouble .... Yes No
   m. Tuberculosis.. Yes No
   n. Persistent cough or cough that produces blood.. Yes No
   o. Persistent swollen neck glands.. Yes No
   p. Low blood pressure.. Yes No
   q. Epilepsy or neurological disorder .... Yes No
   r. Cancer .... Yes No
   s. Any disease, drug or transplant operation that has depressed your immune system .... Yes No
9. Have you had abnormal bleeding?.. Yes No

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10. Do you have any **blood/bleeding disorder** such as anemia?............ Yes No
11. Have you ever had treatment for a tumor or growth? .... Yes No
12. Have you had radiation therapy to the head, neck or jaws?............ Yes No
13. Are you **ALLERGIC to or had a reaction to** (if so, please briefly explain):
    a. **Local anesthetics** .... Yes No
    b. **Penicillin**............ Yes No
    c. Sulfa drugs or **Other antibiotics (please list_________________________)**............ Yes No
    d. **Barbiturates or sleeping pills** .... Yes No
    e. **Aspirin**............ Yes No
    f. Iodine .... Yes No
    g. **Codeine or other narcotics (Vicodin, Percocet…)** .... Yes No
    h. Latex or rubber products............ Yes No
    i. **Egg Allery** .... Yes No
    j. **Soy Bean / Soy Oil Allergy** .... Yes No
    k. Other .... Yes No
14. Have you had any serious trouble associated with previous dental treatment?............ Yes No
    If so, explain:____
    ____
15. Do you have any other condition or disease you think the doctor should know about?............ Yes No
    If so, explain:____
16. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you?............ Yes No
17. Are you wearing contact lenses?............ Yes No
18. Are you wearing removable dental appliances? .... Yes No
19. Do you wish to talk with the doctor privately about anything?............Yes No

Women

1. Are you pregnant or trying to become pregnant .... Yes No
2. Do you have problems associated with your menstrual period (such as heavy bleeding)?............ Yes No
3. Are you nursing?............ Yes No
4. Are you taking birth control pills (antibiotics, if used, can decrease efficacy of pills)? .... Yes No

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient/Guardian Signature: ________________________________ Date: _____________

Doctor's Signature: ____ Date: _____________