



Orofacial & Cosmetic Surgery

Patient's Name: _____
 Patient's Address: _____
 Phone: _____ Age: _____
 Patient's Height _____ Patient's Weight _____
 Referring Doctor: _____ Family Doctor _____

What brings you to our office today? (Chief complaint) _____

Pre-operative Medical History: Please answer all questions by circling (yes) or (no)

1. Do you have or have you ever had:

- | | | | | | |
|---------------------------|-----|----|--------------------------|-----|----|
| 1. Diabetes..... | yes | no | 16. Sleep Apnea..... | yes | no |
| 2. Heart Disease..... | yes | no | 17. Snoring..... | yes | no |
| 3. Heart Attack (MI)... | yes | no | 18. Scarlet Fever..... | yes | no |
| 4. Ankle Swelling.... | yes | no | 19. Epilepsy/Seizures... | yes | no |
| 5. Shortness of Breath. | yes | no | 20. Lung Disease/(COPD) | yes | no |
| 6. Kidney Disease..... | yes | no | 21. Tuberculosis..... | yes | no |
| 7. Rheumatic Fever.... | yes | no | 22. Asthma..... | yes | no |
| 8. Liver Disease..... | yes | no | 23. Venereal Disease.... | yes | no |
| 9. Anemia..... | yes | no | 24. High Blood Pressure | yes | no |
| 10. Abnormal Bleeding. | yes | no | 25. GI Reflux..... | yes | no |
| 11. Recent cold or flu... | yes | no | 26. Ulcers..... | yes | no |
| 12. Glaucoma..... | yes | no | 26. Pregnancy..... | yes | no |
| 13. Mitral Valve Prolapse | yes | no | 27. H.I.V/ A.I.D.S..... | yes | no |
| 14. Heart Murmur..... | yes | no | 28. TMJ pain/clicking... | yes | no |
| 15. Thyroid Disease..... | yes | no | 29. Joint Replacement... | yes | no |

2. Are you under a physician's care? _____ Reason _____

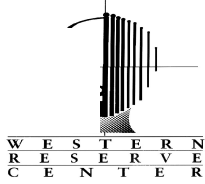
3. List previous hospitalization / operations _____

4. Are you currently pregnant? _____ Do you have a soy or egg allergy? _____

5. Do you have an allergy to Latex? _____

6. Are you presently on medications? (Please list all medications including over the counter medications, Herbal Supplements, Inhalers, Insulin, Birth Control, Diet Pills, etc.)

Please list dose and frequency on next page.



Medication Rec. Form

Patient Name _____ Date _____

Date of Birth _____

Allergies _____

Current Medication List _____

Medication	Dose	Route	Frequency	Reason for taking

Patients Signature _____

FOR OFFICE USE: _____ Date _____

Meds Prescribed by Dr. _____

Medication	Dose	Route	Frequency	Reason for taking

May resume held meds _____ Post Op Inst. given _____

Patients/Escort Sig. _____ Date _____

Reviewed with patient by: _____ Patient Name _____

7. Have you ever had radiation therapy or chemotherapy for cancer? yes no

8. Have you ever had general anesthesia? (i.e. sleep) yes no

Complications: _____

9. Have you ever had local anesthesia? (i.e. Novocaine) yes no

Complications: _____

10. Do you wear contact lenses? yes no

11. Do you smoke? If so, how much? _____

12. Do you drink alcohol? If so, how much? _____

13. Do you use any "street" drugs (i.e. Cocaine, Heroin, Ecstasy or Marijuana?) yes no

14. Have you had any past treatment for chemical dependency or alcoholism? yes no

15. Have/are you being treated for an eating disorder (i.e. anorexia / bulimia)? yes no

16. With previous surgeries, have you experienced?

A. Abnormal bleeding? _____

B. Infection? _____

C. Delayed Healing? _____

D. Other complications? _____

I understand the importance of a truthful health history to assist the Doctor in providing the best care possible. I have answered the above questions to the best of my knowledge.

Signature: _____ Date: _____

(Patient Signature)

Signature: _____ Date: _____

(Doctor Signature)

P: Medical Questionnaire 2009



Orofacial & Cosmetic Surgery

Office Financial Policy

Your healthcare is extremely important to us. To continue to give the best care possible it is important to help us maintain our accounts current. Thus we ask all patients to pay for our services in full when they are rendered.

For cosmetic surgeries, we require one-half of the total fees to be paid at the time you schedule your surgery. This is required in order to hold the date that you choose. For your convenience, we gladly accept MasterCard and Visa. In addition, Western Reserve Center has outside credit lenders to assist with borrowing additional money.

If you have insurance that will be covering your charges, we will gladly assist you in any way we can. To do so we ask you to pay for the portion of the charges not covered by your policy, i.e. deductible, co-pays, and non-covered charges at the time of service, or in the case of surgery, prior to the time of the surgery. You are responsible for payment for your treatment. Your insurance policy is a contract between you and your insurance company. We cannot guarantee third party payment for your claims. Many procedures may require pre-authorization prior to surgery. This may delay the planned procedure and other payment arrangements may need to be made if the procedures are done prior to the written pre-authorization.

It is very important to understand that we care very much for our patients and give them our complete attention. Your appointment is exclusive for you. If you break the appointment, or simply forget it, we do not have another patient for that time slot. We take that risk for you because we know your time is valuable, so please remember ours is too.

There will be a \$35.00 charge for all checks returned to us. All delinquent accounts will be handled according to collector's policies. In addition, a "no-show" policy will be enforced. A twenty-one-day advance cancellation notice on all scheduled cosmetic surgeries is required. If this not complied with, a prorated portion of the fee will be allocated for administrative purposes. Thank you for your consideration.

Signature: _____ Date: _____

Western Reserve Center Patient Registration

Date: _____ Cell Phone: _____
Work Phone: _____

Patient Information

Name: _____ Social Security # _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birthdate: _____ Marital Status: _____

Employer's Name: _____ Occupation: _____

Whom May we thank for referring you? _____

Incase of emergency who should be notified? _____

Phone: _____ Business Phone: _____

Email/Website
Address: _____

Primary Medical Insurance

Person responsible for Account: _____

Relation to Patient: _____ Birthdate: _____ S. S. # _____ - _____ - _____

Address (if different to patient's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Person Responsible Employed By: _____ Business Phone: _____

Insurance Company Name: _____

Group # _____ Subscriber # _____

Primary Dental Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name: _____ Relation to Patient: _____ Birthdate: _____

Insurance Company: _____ Group # _____

Subscriber # _____ Insurance Phone # _____

Western Reserve Center for Orofacial & Cosmetic Surgery

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 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 April 15, 2003 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 the 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 you.

HEALTHCARE OPERATIONS: We may use and disclose your health information on 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 is 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 of 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 locating, 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 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 authorize 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.

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 .25 for each page, \$20.00 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 15, 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).

ALTERNATE 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.

AMMENDMENT: 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 may also 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 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: Antonela Ceabuca

Telephone: 216-227-3333 Fax: 216-226-3700

Email: wrcparma@aol.com

Address: 14700 Detroit Avenue, Lakewood, Ohio 44107

Front Office/Pt. Registration Packet

2/09



Orofacial & Cosmetic Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize the release of all information, without limitations regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical-dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I request that you release the above information to:

Doctor

Address

City

State

Zip

Requesting: _____

Patients Name

Pt's I.D. Number

Patients Birthday

Patients Signature

Date

Witness' Signature

Date

WESTERN RESERVE CENTER FOR
OROFACIAL AND COSMETIC SURGERY

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY RIGHTS**

Western Reserve Center for Orofacial and Cosmetic Surgery, Inc. is required to provide you with a copy of the Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this Form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

Patient Name: _____
(print)

Additional information requested:

1. At which of the following number(s) do we have permission to contact or leave messages for you regarding your treatment, medication or financial/insurance information?

- | | | | | | |
|-----------------------|------|---------------------|-----------------------|------|---------------------|
| <input type="radio"/> | Home | ____ - ____ - _____ | <input type="radio"/> | Cell | ____ - ____ - _____ |
| <input type="radio"/> | Work | ____ - ____ - _____ | <input type="radio"/> | Cell | ____ - ____ - _____ |

2. Other than your insurance carrier, who may we speak with about your healthcare information?

- | | | | | |
|-----------------------|-------------|-------|-------|-------|
| <input type="radio"/> | Spouse Name | _____ | Phone | _____ |
| <input type="radio"/> | Child Name | _____ | Phone | _____ |
| <input type="radio"/> | Child Name | _____ | Phone | _____ |
| <input type="radio"/> | Parent Name | _____ | Phone | _____ |
| <input type="radio"/> | Other Name | _____ | Phone | _____ |

3. Any additional limitations or instructions on disclosure of your health information: _____

_____.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and I have had an opportunity to review it.

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
 - Due to an emergency situation it was not possible to obtain an acknowledgment.
 - We are not able to communicate with the patient.
 - Other (Please provide specific details).
-

Employee Signature

Date
