Frank A. Cornella, D.D.S., M.D., P.C.

ORAL SURGERY of SPRINGFIELD
3237 East Sunshine, Springfield, Mo. 65804

PATIENT AND INSURANCE INFORMATION

PATIENT NAME: _____SOCIAL SECURITY#:_____

HOME PHONE #:_____ CELL PHONE #:_____

EMAIL: _____

HOME ADDRESS:_____
MAILING
ADDRESS: _____CITY _____ZIP_____

BIRTHDAY: _____ MARITAL ST: ___ SEX: F / M

EMERGENCY CONTACT:_____PHONE:_____

PRIMARY PHYSICIAN: _____DENTIST:_____

ORTHODONTIST: _____REFFERED BY:_____

REASON FOR VISIT TODAY: _____

PARENT/GUARDIAN ACCOMPANYING MINOR

NAME: _____ RELATION TO PATIENT_____

SOCIAL SECURITY #:_____ PHONE #: _____ BIRTHDAY:_____

STREET ADDRESS: _____ CITY _____ZIP_____

PLEASE LIST AN ADULT (18 OR OLDER) WHO CAN ACCOMPANY MINOR IN PARENT/GUARDIAN'S ABSENCE.

NAME:_____ RELATION TO PATIENT:_____

PHONE #:_____

The undersigned hereby consents to and authorizes Frank A. Cornella, DDS, MD, PC its physician and surgeon, to furnish medical services and treatment to the above named**. I agree that all information provided above is accurate and up to date.**

DATE:_____ SIGNATURE:_____

SUBSCRIBER INFORMATION FOR THE INSURANCE

NAME:_____ RELATION TO PATIENT:_____

SSN #:_____ BIRTHDAY:_____ PHONE #:_____

ADDRESS:_____ CITY:_____ ZIP:_____

INSURANCE COMPANY:_____

ID#:_____GROUP:_____

Oral Surgery of Springfield HIPAA Compliance Patient Consent Form

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and, upon that, all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

May we phone to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by (PRINT NAME PLEASE):_____

Patient or Legal Guardian Signature:_____ Date:_____

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. **The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations**. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

I would like a copy of this office's Notice of Privacy Practices: YES NO

PATIENT or Legal Guardian Signature:_____ **Date**:_____

_____ ******You may refuse to sign this acknowledgment** _____

_____ **For Office Use Only** _____

Patient refused to sign:_____