OMSA
Michael H. Porter, DDS
John W. Ratliff, DDS

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES

PATIENT REGISTRATION FORM

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. The information we request will help us to prepare for your visit and ensure a smooth experience. If you have any questions please do not hesitate to our office.

PERSONAL DETAILS

Last Name:		First Name:		Middle:		Preferred:	
Birth date:		SS#		Gender:	☐ Male ☐ Female ☐ Other	Married:	☐ Yes ☐ No
Work Phone:		Home Phone:		Mobile Phone:			
Email:							
Occupation:							
Dentist's Name:							
Emergency Contact Name:							
Phone Number:		Relationship to You:					

ADDRESS INFORMATION

Check box if same for entire family: ☐					
Address:					
Apartment or Unit Number:					
City:		State:		Zip:	
Home Phone:					

DENTAL INSURANCE

Please present insurance card(s) to receptionist upon arrival

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child	DOB:		SS#	
Subscriber Name:		Subscriber ID#			
Insurance Company:		Phone:			
Employer:		Group Name:		Group#	

ADDITIONAL DENTAL INSURANCE

Please present insurance card(s) to receptionist upon arrival

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child				
Subscriber Name:		Subscriber ID#			
Insurance Company:		Phone:			
Employer:		Group Name:		Group#	

☎ 843-554-5003 🖷 843-745-0003 ✉ frontdesk@omsasc.com 🌐 www.omsasc.com

MEDICAL INSURANCE

Please present insurance card(s) to receptionist upon arrival

Your relationship to subscriber:	☐ Self ☐ Spouse ☐ Child		DOB:	SS#	
Subscriber Name:			Subscriber ID#		
Insurance Company:			Phone:		
Employer:		Group Name:		Group#	

FINANCIAL INFORMATION

Please let us know who will be financially responsible for your treatment.

Person responsible for account:	☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other:				
Please fill out the following information for the financially responsible party:					
IF YOU ARE THE RESPONSIBLE PARTY, DO NOT FILL OUT THIS SECTION.					
Birthdate:		Social Security Number:			
Address:					
City:		State:		Zip:	
Home Phone :			Mobile Phone:		
Email:					

PHARMACY INFORMATION

Name of Pharmacy:					
Street Address:					
City:		State:		Zip:	
Phone Number:					

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MEDICAL HISTORY

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. The information we request will help us to prepare for your visit and ensure a pleasant and smooth experience. If you have any questions please do not hesitate to contact our office at 843-554-5003.

GENERAL INFORMATION

Last Name:		First Name:	
Birthdate (mm/dd/yyyy):		Gender:	☐ Male ☐ Female ☐ Other
Preferred Pronoun:	☐ Mr ☐ Mrs ☐ Ms ☐ Other	Height:	Weight:

Name of medical doctor:	
Date of last medical exam:	

Any changes in your general health in the past year? If so, please describe:
Have you ever had a serious illness? If so, please describe:
Have you been hospitalized or had surgery in the past 5 years? If so, please describe:

DO YOU HAVE OR HAVE YOU EVER HAD *(PLEASE CHECK ALL THAT APPLY)*

Cardiovascular

- ☐ Heart Attack/ Coronary Artery Disease
- ☐ Chest pain
- ☐ Irregular Heart Rate (Atrial Fibrillation, Arrhythmia, Palpitations, Flutter)
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Surgery (Bypass or Stent)
- ☐ Heart Valve Replacement
- ☐ Pacemaker
- ☐ Other Heart Trouble Not Listed

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Post Nasal Drip/Chronic Cough
- ☐ Sinus Problems
- ☐ Shortness of Breath

Hematology/Immune

- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Bruise or Bleed Easily
- ☐ Blood Thinner
- ☐ HIV/AIDS (If so please know your most recent CD4 and Viral Load count)
- ☐ Disease or Medication that may depress your immune system
- ☐ Autoimmune Disorder or Immunomodulated Disease
- ☐ History of Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Organ Transplant

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DO YOU HAVE OR HAVE YOU EVER HAD *(PLEASE CHECK ALL THAT APPLY)*

Neurologic/Psychologic

- ☐ Seizure or Epilepsy
- ☐ Depression
- ☐ Anxiety
- ☐ Chronic Pain
- ☐ Pain Management
- ☐ History of Addiction or Substance Abuse
- ☐ Psychiatric Illness

Endocrine

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Take Insulin
- ☐ Hypothyroidism
- ☐ Other Thyroid Disorder

Skeletal/Bone/Muscular

- ☐ Arthritis / Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Joint Replacement
- ☐ Have taken medications to prevent osteoporosis / Loss of bone density

Other Systems

- ☐ Kidney Disease
- ☐ Liver Disease (Jaundice, Hepatitis, Other)
- ☐ Acid Reflux/GERD
- ☐ Other GI disease
- ☐ Glaucoma
- ☐ Snoring or Sleep Apnea

Medical Condition(s) Not Listed

- ☐ _____
- ☐ _____
- ☐ _____

ALLERGIES, INTOLERANCES AND AVOIDANCES

Please be prepared with a list of all your allergies at the time of your appointment.

Do you have allergies to any of the following?

- ☐ Local Anesthetics (Novacaine, Lidocaine, etc.)
- ☐ Penicillin or Penicillin Family Antibiotics (Amoxicillin, Cephalosporins)
- ☐ Other Antibiotics _____
- ☐ Aspirin ☐ Ibuprofen
- ☐ Codeine ☐ Other Narcotics
- ☐ Latex ☐ Sulfa Drugs
- ☐ Soy ☐ Eggs
- ☐ Other Food Product Allergy _____
- ☐ Chemical Allergy _____
- ☐ Nickel
- ☐ Other Metal Allergy (Jewelry, etc.) _____
- ☐ Have you ever been advised to avoid taking a medication not listed?
- ☐ _____
- ☐ Do you have an allergy that is not listed? _____

Are you taking any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants or Blood Thinners
- ☐ Aspirin or Ibuprofen
- ☐ Steroids
- ☐ Tranquilizers, Sleeping Aids, Anti-Depressants
- ☐ Narcotics
- ☐ Diet Pills / Supplements
- ☐ Bone Density Medications such as Bisphosphonates (Reclast, Foasamax, Actonel, Boniva, Aredia, Zometa, Prolia, etc.)
- ☐ Insulin
- ☐ Oral Anti-Diabetic Drugs
- ☐ High Blood Pressure Medications
- ☐ Other Heart Drugs

MEDICATIONS

Please list ALL Medications you are taking, including diet pills, birth control, over the counter medications and holistic/herbal remedies:
We recommend that you use bottles to copy the names of your medications accurately and with correct spelling as this will help to keep you safe.

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MEDICATIONS *(Please use this space if you take additional medications not listed on the previous page)*

SURGERIES *Please list all surgeries that you have had below:*

ADDITIONAL INFORMATION

Do you ever smoke?	☐ Yes ☐ No	If so how many packs per day:		and for how many years:	
Do you chew tobacco?	☐ Yes ☐ No				
Do you have a history of chemical dependency or addiction?	☐ Yes ☐ No				
Do you have a history of alcohol dependency?	☐ Yes ☐ No				
Have you had any serious problems with previous dental treatment?	☐ Yes ☐ No				
If so, please explain:					
Have you or an immediate family member ever had an issue with anesthesia?	☐ Yes ☐ No				
Do you have any problems, disease or conditions not listed above that you think the doctor should know about?					
If so, please provide details:					
Is there anything you would like to talk to the doctor about privately?	☐ Yes ☐ No				

FEMALE PATIENTS ONLY

Please provide the date of your last menstrual period?			
Are you pregnant or is there any chance you might be pregnant?	☐ Yes ☐ No	If so, when is your expected delivery date?	
Are you nursing?	☐ Yes ☐ No	Are you using oral contraceptives/birth control?	☐ Yes* ☐ No

*If so it is important you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use additional forms of birth control for one full cycle of birth control pills after a course of antibiotics or other medications. Please consult with your physician for more information if this pertains to you.

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PLEASE READ AND SIGN BELOW:

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care.
I have read and understand the above information and have had my questions answered.

Patient or Guardian's Name:	
Date:	

Patient or Guardian's Signature:	

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Michael H. Porter, DDS
John W. Ratliff, DDS

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES, LLC

MEDICARE WAIVER

This contract is entered into by and between **Dr. Michael H. Porter and Dr. John W. Ratliff** (hereafter called the "Physicians"), whose principal medical office is located at **2320 Cosgrove Ave, Charleston, SC 29405** and patient _____ [First Name and Last Name] (hereafter called "Beneficiary"), who resides at _____ [Address], and shall become effective on this 1st day of January, 2023, and shall expire on the 1st day of January, 2025, unless otherwise renewed in accordance with the 42 U.S.C. 139a: 42 C.F.R. 405, Subpart D.

Physician Obligations:

The physician acknowledges that he is excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during the time when the beneficiary requires emergency care service or urgent care services, except that the physician may furnish emergency or urgent care services to Medicare beneficiary in accordance with 42 C.F.R. 405.440

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that he must enter into a contract for each opt-out period.

Beneficiary Obligations:

The beneficiary or his or legal representative, accepts full responsibility for payment of the physician's charges for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payments will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representatives, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative agrees not to submit a claim nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

Acknowledge that Medicare plans do not, and that other supplemental insurance plans "such as FEP" may elect not to make payment for items and services furnished by the physician or practitioner under the opt out contract.

_____
Dr. Michael H. Porter

_____
Dr. John W. Ratliff

Patient: _____

Date: _____

Witness: _____

Date: _____

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John W. Ratliff, DDS

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Last Name:		First		MI		(Maiden Name or Alias)	
Date of Birth:		Medical Record #:				Phone:	
Address:		City:		State:		Zip:	
Date of Service:							

☐ **I authorize** Dr. Michael Porter and Dr. John W. Ratliff to use, disclose and retrieve my protected health information for his/her own purposes of treatment, payment, and health care operations.

☐ **I authorize** Dr. Michael Porter and Dr. John W. Ratliff to disclose the following records related to the date above:

Records:

☐ All records

☐ Medical Records ☐ Diagnostic Records (lab, x-ray, etc.) ☐ Treatment Records

☐ HIV/STD ☐ Drug and alcohol related ☐ Billing/Claims Records

Please release these records to:

Name:							
Address:		City:		State:		Zip:	
Phone:		Fax:		Email:			

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

You may **revoke this authorization** in writing at any time by sending written notification to:
Oral and Maxillofacial Surgery Associates
2320 Cosgrove Ave
Charleston, SC 29405

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing.

Patient or Legal Representative Signature — Date: _____

Print Patient or Legal Representative Name/Relationship — Date: _____

Charleston Oral and Maxillofacial Surgery Associates LLC.

2320 Cosgrove Ave
Charleston, SC 29405
843-554-5003 | oralsurgery@omsasc.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: January 1, 2020

This Notice of Privacy Practices applies to the following organizations.

Charleston Oral and Maxillofacial Surgery Associates, LLC.

Privacy Officer: Mira Mehes
843-554-5003 | oralsurgery@omsasc.com

Charleston Oral and Maxillofacial Surgery Associates, LLC (OMSA)

Notice of Privacy Practices

Last Name: _____

First Name: _____

Birthdate: _____

Date: _____

Please take a moment to read our Notice of Privacy Practices below. Once you have had the opportunity to read and consider the contents of our Notice of Privacy Practices, please sign at the end of this document. Thank you, OMSA Team

Signature _____

Date _____