

JF Lopez DDS, MD, RPh, PA
Oral and Maxillofacial Surgery

MEDICAL HISTORY FORM

Name: _____

Date of Birth: _____

Sex: _____

Height: _____

Weight: _____

For the following questions, circle yes or no, whichever applies? Your answers are for our records only and will be considered confidential.

Are you now under the care of a physician? ----- Yes No

The name and address of my physician is: _____

My last physical exam was on _____

• If so, for what condition? _____

Are you in good health? ----- Yes No

Has there been any change in your health in the past year? ----- Yes No

Have you had any serious illness, operation or hospitalization within the past 5 years? ----- Yes No

Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills ----- Yes No

If so, please list _____

Do you have or have you had any of the following diseases or problems?

- 1. Arthritis ----- Yes No
- 2. Asthma ----- Yes No
- 3. Cancer ----- Yes No
- 4. Damaged heart valves ----- Yes No
- 5. Diabetes ----- Yes No
- 6. Epilepsy or neurological disorder ----- Yes No
- 7. Fainting spells or seizures ----- Yes No
- 8. Frequent or recurring mouth sores ----- Yes No
- 9. Heart trouble -----
 - a. Angina ----- Yes No
 - b. Arrhythmias ----- Yes No
 - c. Arteriosclerosis ----- Yes No
 - d. Artificial valves ----- Yes No
 - e. Chest pain upon exertion? ----- Yes No
 - f. Do your ankles swell? ----- Yes No
 - g. Heart attack ----- Yes No
 - h. Heart murmur ----- Yes No
 - i. High blood pressure ----- Yes No
 - j. Low blood pressure ----- Yes No
 - k. Rheumatic Heart Disease ----- Yes No
 - l. Shortness of breath w/exercise --- Yes No
 - m. Other heart condition _____
- 10. Hepatitis ----- Yes No
- 11. Jaundice ----- Yes No
- 12. Jaw joint (TMJ) ----- Yes No
- 13. Kidney trouble ----- Yes No
- 14. Liver disease ----- Yes No
- 15. Painful, swollen joints ----- Yes No
- 16. Persistent cough that produces blood ----- Yes No
- 17. Persistent swollen neck glands ----- Yes No
- 18. Seasonal Allergies ----- Yes No
- 19. Sinus trouble ----- Yes No
- 20. Stomach ulcer or hyperacidity ----- Yes No

- 21. Stroke ----- Yes No
- 22. Thyroid problems ----- Yes No
- 23. Have you had abnormal bleeding ----- Yes No
 - a. Coumadin, Warfarin ----- Yes No
 - b. Other blood thinners ----- Yes No
- 24. Have you ever required a blood transfusion Yes No
- 25. Do you have any:
 - a. Blood disorder, anemia ----- Yes No
- 26. Are you taking:
 - a. Vitamins, homeopathic remedies -- Yes No
- 27. Any disease drug or transplant operation that has depressed your immune system:
 - a. HIV, AIDS ----- Yes No
 - b. TB ----- Yes No
 - c. Organ transplant ----- Yes No
- 28. Respiratory problems:
 - a. Bronchitis ----- Yes No
 - b. Emphysema ----- Yes No
- 29. Have you had any serious trouble associated with previous dental treatment: ----- Yes No
 - a. If so, explain: _____
- 30. Do you have any other condition or disease you think the doctor should know about: ----- Yes No
 - a. If so, explain: _____
- 31. Are you allergic to or have you had a reaction to:

• Aspirin -----	Yes	No
• Barbiturates or sleeping pills -----	Yes	No
• Codeine or other narcotics -----	Yes	No
• Iodine -----	Yes	No
• Latex -----	Yes	No
• Local anesthetics -----	Yes	No
• Sulfa drugs -----	Yes	No
• Penicillin or antibiotics -----	Yes	No
• Other allergies -----	Yes	No

- Are you wearing **Contact Lenses**? ----- Yes No
- Are you wearing **Removable Dental Appliances**? ----- Yes No
- Do you take **FOSMAX** or similar **BISPHOSPHONATE** type drugs? ----- Yes No

Women (only)

Are you pregnant or trying to become pregnant?.....	Yes	No
Do you have problems associated with your menstrual period?	Yes	No
Are you nursing?.....	Yes	No
Are you taking birth control pills?	Yes	No

****PLEASE BE ADVISED THAT WHEN TAKING MOST ANTIBIOTICS THEY WILL AFFECT BIRTH CONTROL MEDICATION BY MAKING IT INEFFECTIVE RESULTING IN PREGNANCY UNLESS OTHER PREVENTATIVE METHODS ARE TAKEN****

Chief Dental Complaint: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: «pativisit» Patient's Signature: _____

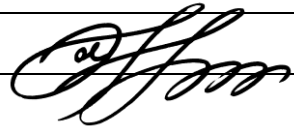
FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

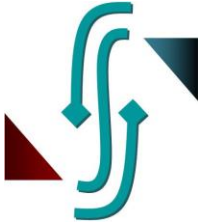
Dental management considerations: _____

Date: _____ Doctor's Signature: _____



Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____



JF Lopez DDS, MD, RPh, PA
Oral and Maxillofacial Surgery

PATIENT INFORMATION

DATE: _____ SEX: M / F SINGLE MARRIED

PATIENT NAME: _____ AGE: _____

DOB: _____ SOC. SEC# _____ REFERRING DENTIST: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____ CELL PHONE: _____

FAX: _____ E-MAIL: _____ DRIVERS LIC: _____

EMPLOYER: _____ OCCUPATION: _____ # YEAR'S: _____

IF PATIENT IS A MINOR, GIVE PARENTS OR GUARDIAN NAME _____

POLICY HOLDER INFORMATION

DATE: _____ SEX: M / F SINGLE MARRIED

NAME: _____ DOB: _____ AGE: _____

SOC. SEC# _____ HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ FAX: _____ E-MAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____ OCCUPATION: _____ # YEAR'S: _____

MEDICAL / DENTAL INSURANCE INFORMATION

MEDICAL CARRIER: _____ ID #: _____ GROUP # _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CARRIER PHONE # _____

DENTAL CARRIER: _____ ID #: _____ GROUP # _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CARRIER PHONE # _____

SPOUSE'S INFORMATION

NAME: _____ DOB: _____ SEX: M / F

WORK PHONE: _____ EXT: _____ CELL PHONE: _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: _____

COMPLETE ADDRESS: _____

PHONE #: _____

SIGNATURE (PARENT'S SIGNATURE IF MINOR): _____

UPDATES (DATE & INITIAL): _____

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this dentist named on the benefits otherwise payable to me.

Signature _____

JF Lopez DDS MD RPh PA
1770 St. James PL
#512
Houston
Texas, 77056

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at JF Lopez DDS MD RPh PA understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you 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 10/04/2016, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 was 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 another person to the extent necessary to help with your healthcare or with payment for 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 location, 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a 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 authorized 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.

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages or letters).

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, mailing, 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 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 14, 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at 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.

Amendment: 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 also may submit a written complaint to the U.S. Department of Health and Human Services 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 support your right to the 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.

Privacy Officer: Diana Lopez
Telephone: 7136228607
E-mail: manager@jflopezoms.com
Address: 1770 St. James PL
#512
Zip Code: 77056
State: Texas
City: Houston

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, _____ have been informed of this office's Notice of Privacy Practices.

Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)