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

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

PATIENT, BILLING, 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: ____

SUBSCRIBER TO THE INSURANCE

NAME:_______________________________________ PATIENT RELATION:______________________

SSN #:_____________________ BIRTHDAY:________________ PHONE #:_______________________

ADDRESS:________________________________ CITY:______________________ ZIP:__________

INSURANCE COMPANY:____

ID#:_________________________________GROUP:______________________

ADULT ACCOMPANYING A MINOR (Please Circle One) PARENT/GUARDIAN

NAME: _______________________________________ SOCIAL SECURITY #:________________

PHONE #: _______________________ BIRTHDAY:__________________________________

ADDRESS: _____________________________ CITY _________________________ZIP___________

ADULT (18 OR OVER) ACCOMPANYING CHILD IN ABSENCE OF PARENT OR GUARDIAN

NAME:________________________________ RELATION:__________________________________

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 minor, whenever the minor is presented for treatment. I will pay the charges incurred:

DATE:______________________ SIGNATURE:____

___Parent ____ Guardian

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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 practice 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, email, or send a text 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:

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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.

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

Patient or Legal Guardian Signature:______________________________Date:____________

____

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:____