Dr. David Mueller

Virginia Facial Surgery

DAVID P. MUELLER, D.D.S. & ASSOCIATES
PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name:_____ Today's Date_____

Sex:_____ Age:_____ Birth Date: _____ Soc. Sec. #_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Employer:_____ Occupation:_____

E-MAIL ADDRESS:_____

Responsible Party's (If other than patient)—Subscriber of insurance

Name:_____ Relationship to Insured:_____

Soc Sec. #_____ DOB:_____ Driver Lic#_____

Address:_____

City:_____ State:_____ Zip:_____

Employer:_____Occupation:_____Phone#:_____

IN THE EVENT OF ANY EMERGENCY:

Emergency contact:_____ Phone:_____

Physician:_____ Phone:_____

Referring Dentist/Ortho:_____Phone:_____

Reason for Visit:_____

Would you like to talk with Dr. Mueller about of the following services:

Skin care Glycolic acid Botox Laser mole removal
Lip Enhancement Collagen Chin Enhancement Eyelid Enhancement
Laser Facelift Facelift Neck Liposuction Cheek Enhancement

CURRENT MEDICATION HISTORY Name of person completing _____ date/time_____

CURRENT MEDICATION HISTORY	MEDICATION NAME and Dose	MEDICATION NAME and Dose

MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

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

1. Are you in good health? ... Yes No
2. Has there been any change in your health in the past year? ... Yes No
3. My last physical exam was on _____ / _____ / _____
4. Are you now under the care of a physician? ... Yes No
   If so, for what condition? _____
5. The name and address of my physician is: _____
   _____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ... Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills ... Yes No
   If so, please list _____

A. **Are you currently prescribed medical grade marijuana?** Yes No

If so, please provide your medical grade marijuana card to the front desk

8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur ... Yes No
   b. Rheumatic Heart Disease ... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ... Yes No
      1. Chest pain upon exertion? ... Yes No
      2. Shortness of breath after mild exercise? ... Yes No
      3. Do your ankles swell? ... Yes No
      4. Do you need to be **PRE-MEDICATED BEFORE ANY SURGERIES (ANY HEALTH CONDITION)**? Yes No
   d. Allergies ... Yes No
   e. Sinus trouble ... Yes No
   f. Asthma or hay fever ... Yes No
   g. Fainting spells or seizures ... Yes No
   h. Diabetes ... Yes No
   i. Hepatitis, jaundice or liver disease ... Yes No
   j. Frequent or recurring mouth sores ... Yes No
   k. Thyroid problems ... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ) ... Yes No
   n. Stomach ulcer or hyperacidity ... Yes No
   o. Kidney trouble ... Yes No
   p. Tuberculosis ... Yes No
   q. Persistent cough or cough that produces blood ... Yes No
   r. Persistent swollen neck glands ... Yes No
   s. Low blood pressure ... Yes No
   t. Epilepsy or neurological disorder ... Yes No
   u. Are you taking vitamins or homeopathic remedies ... Yes No
   v. Cancer ... Yes No
   w. Any disease, drug or transplant operation that has depressed your immune system ... Yes No
9. Have you had abnormal bleeding? ... Yes No
   a. Have you ever required a blood transfusion? ... Yes No
10. Do you have any blood disorder such as anemia? ... Yes No
11. Have you ever had treatment for a tumor or growth? ... Yes No
12. Do You SMOKE? ... Yes No
13. Are you allergic to or have you had a reaction to:
   a. Local anesthetics ... Yes No
   b. Penicillin or antibiotics ... Yes No
   c. Sulfa drugs ... Yes No
   d. Barbiturates or sleeping pills ... Yes No
   e. Aspirin ... Yes No
   f. Iodine ... Yes No

g. Codeine or other narcotics ..... Yes No
h. Other-METAL ALLERGIES? ..... Yes No

14. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
If so, explain:_____
_____

15. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
If so, explain:_____

16. Are you wearing contact lenses? ..... Yes No
17. Are you wearing removable dental appliances? ..... Yes No
18. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

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

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:_____Patient's Signature:_____

What is your preferred pharmacy?

Name: _____

Address: _____

_____

Phone #:_____

Dr. David Mueller

Virginia Facial Surgery

We will file your insurance as a courtesy. However, it is important for you to understand that you are solely responsible for your account. Therefore, it is important that all insurance information is disclosed at this time. Please make sure that your information is accurate and up to date.

complete in full

Primary Dental Insurance

✓

Policy Holder Name: _____

Date of Birth: _____ SS#: _____

Employer: _____

Insurance Carrier Name: _____

Customer Service Phone Number: _____

Claims Address: _____

Id#: _____ Group: _____

Secondary Dental Insurance

Policy Holder Name: _____

Date of Birth: _____ SS#: _____

✓

Employer: _____

Insurance Carrier Name: _____

Customer Service Phone Number: _____

Claims Address: _____

Id#: _____ Group: _____

Primary Medical Insurance

Policy Holder Name: _____

Date of Birth: _____ SS#: _____

✓

Employer: _____

Insurance Carrier Name: _____

Customer Service Phone Number: _____

Claims Address: _____

Id#: _____ Group: _____

Secondary Medical Insurance

Policy Holder Name: _____

Date of Birth: _____ SS#: _____

✓

Employer: _____

Insurance Carrier Name: _____

Customer Service Phone Number: _____

Claims Address: _____

Id#: _____ Group: _____

Dr David P. Mueller, D.D.S.
1157 First Colonial Rd, Suite 101
Virginia Beach Va 23455

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office This will include, but not limited to, appointments day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than the USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

✓

__Work Cell __Work Phone __ Work Email __Work Fax __ Mail to Work __ Personal Cell
__ Home Phone __ Home Email ___ Home Fax __Mail to Home ___Emerg. Contact __Interpreter Contact
__ **Any of the above**

List names of who can have access to your dental/medical chart information: Circle Type.

State what part of your chart: Financial, Treatment, Health history, is allowed to be disclosed or copied

✓ _____ ___ _____ **Full** access / **Partial** access _____ ___

__ _____ _ _____ **Full** access / **Partial** access _____ ___ _ ... IE. parent signif cant other

✓ _ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

___ _ _____ _____ _ _____ _

✓ **Print Patient's Name:** _____ **Date** _____

✓ **Print Legal Guardian's Name:** _____ **Date** _____

✓ **Signature of Patient or Legal Guardian:** _____ **Date** _____

____Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer

Office Staff Signature_____ **Printed Name**_____ **Date** _____

David P. Mueller, D.D.S., F.A.B.O.M.S.
FACIAL COSMETIC SURGERY & ORAL MAXILLOFACIAL SURGERY

Diplomat, American Board of Oral & Maxillofacial Surgery & American Academy of Cosmetic Surgery

Appointment Confirmations/Broken Appointments

We understand that everyon's time is important. However, once you make an appointment for either yourself or someone in your family, we expect you to keep it unless it is cancelled at least 48 hours before the time slot that has been reserved for you or your family member.

We will give you several opportunities to cancel and reschedule well in advance should you need to do so. Our office policy is to call 2 days prior to remind you of your appointment. We will leave a message if we are unable to speak with you, so please call back to confirm the appointment.

We reserve the right to charge you $50.00 for an exam appointment and $500.00 for a surgery appoinment that is broken, not cancelled, or rescheduled at least 48 hours before your confirmed scheduled appointment.

Our office also understands that circumstances do arise that may prevent you from coming even if you may have confirmed. But please do your best to give us at least a 48 hour notice so we may use that time to serve other patients.

X _____

Patient or Guarantor:

1157 First Colonial Road, Suite 101, Virginia Beach, VA 23454 * 757.496.8066
ww.vafacialsurgery.com

David P. Mueller and Associates, Inc.
Financial Agreement and Release of Information

Authorization and Consent for Treatment/X-rays

I hereby give authorization for examination and necessary treatment and x-rays by David P. Mueller and Associates, Inc. and/or medical staff members on behalf of myself/minor for which I am consenting. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the patient's blood or bodily fluids. In the event of such direct exposure in a manner that may, according to the Centers of Disease Control Guidelines, transmits AIDS (Acquired Immune Deficiency Syndrome), a sample of the patients blood will be tested for the presence of infectious disease such as hepatitis, syphilis, and HIV. I consent that the results of the test will be released to me and the health care worker who suffered exposure. I further understand that I will be given an explanation about the procedure and will be given the opportunity to ask questions about the procedure. _____ INITIAL ✓

Release of Information

I hereby authorize the release of any and all medical and/or charge information as is necessary for third party reimbursement from any governmental agency or insurance payer involved in the payment of my/minor for which I am consenting medical treatment. I authorize the release of any and all medical information to any physician, facilty and/or hospital involved in my/minor for which I am consenting care. In addition, I authorize representative of David P. Mueller and Associates to leave appointment and testing reminders on my answering machine. _____ INITIAL ✓

Obligation of Payment

I direct and assign payment from my Insurance Company to David P. Mueller and Associates, Inc. I understand that my insurance policy is a contract between me and my insurance company, and that I am responsible to David P. Mueller and Associates, Inc. for any charges not covered by my insurance including co-payments, deductibles, and fees for non-covered services. Upon default on any payment due to David P. Mueller and Associates, Inc., I agree to pay all cost of collections and court proceedings including collection agency fees of 33-1/3% or any attorney's fees of 33-1/3%. Some insurance plans (Medicare, Blue Cross, Tricare, and Sentara) require lab work be billed by the laboratory performing the testing. In the instances, I understand that I will receive a separated statement and bill from the lab performing the test. I have read and agree to the terms of the Patient Financial Policy ._____INITIAL ✓

Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Charges not billed to my insurance company are due prior to leaving the office (i.e. co-payments and deductibles). I have been informed that a fee of $30.00 will be charged to my account for all returned checks. Returned check fees can only be paid in cash, money order or credit card. An Interest Rate of 1.5% (18% APR) will be added to accounts 90 days past due. Please direct all billing inquiries to our Billing Representative. _____ INITIAL ✓

Acknowledgement/Privacy Practices

I patient/guardian acknowledge that I have been provided with David P. Mueller and Associates, Inc. Notice of Privacy Practices (HIPPA) and given the opportunity to ask questions about the information provided. I certify that I understand the contents of this form. _____ INITIAL ✓

Video/Audio Restrictions

I understand and acknowledge that to ensure confidentiality and privacy, any type of Video/Audio recording is strictly prohibited at any location in this office. _____INITIAL ✓

Patient Name: _____Guarantor: _____

Date: _____ Witness: _____