3394 N. Futrall Drive, Suite 2
Fayetteville, AR 72703
Phone: (800) 476-7131

Welcome! We are so glad that you are here. Please complete this form so that we can provide you

Patient Name: _____ Date of Birth: _____

Patient Height _____ Weight_____ *For Pediatric Patients*- Birth Weight_____ Male / Female

Address: _____State: _____ Zip: _____

Phone: _____ Email:_____ Preferred Method of Contact:_____

IF MINOR *Please fill out*

Mother's Name: _____ Father's Name:_____

Phone:_____ Email:_____ Phone:_____ Email:_____

----------Medical Information----------

What is the reason for your visit today? _____

Who referred you to our office? _____

Primary Care Doctor Name: _____ Phone: _____

Address: _____State: _____ Zip: _____

Last Visit to Doctor: _____ Pharmacy Location/Phone:_____

Have you been under the care of a medical doctor in the past two years? If yes, why?_____

Have you been a patient in a hospital the last 5 years? If yes, why?_____

Medical Conditions:_____

Past Medical Conditions:_____

Medications & Dosage:_____

Previous Medications:_____

Allergies or adverse reactions to medications or substances?_____

Additional Doctors in Care Team: _____

_____

Please describe your current Medical or Dental problems:_____

CLEFT and CRANIOFACIAL CENTER of NWA

Have you had or do you currently have ...	YES	NO	Notes	Have you had or do you currently have ...	YES	NO	Notes
Cancer?				Stomach ulcers?			
Radiation therapy/ chemotherapy?				Swollen ankles, arthritis or joint disease?			
Rheumatic fever?				Contagious diseases?			
Heart murmur/Heart				HIV, AIDS?			
High blood pressure?				Problems of the immune system?			
Bronchitis, chronic cough, pneumonia?				Mental health problems/ psychiatric treatment?			
Heart attack(s)?				Drugs (marijuana,			
Chest pain, angina?				Alcoholic beverages?			
Asthma, hay fever, or sinus problems?				Bleeding tendency (abnormal bleeding)?			
Tuberculosis?				Are you pregnant? Are you breastfeeding?			
Difficulty breathing, emphysema?				Pain or clicking of jaws when eating?			
Do you smoke?				TMJ problems?			
Eye disease/glaucoma?				Snoring or sleep disturbance?			
Problems with				Hearing loss?			
Frequent headaches?				Anemia/sickle cell?			
Convulsions, epilepsy, seizures?				Jaundice, hepatitis or liver disease?			
Stroke?				Malignant hyperthermia?			
Thyroid trouble?				Cerebral palsy?			

CLEFT and CRANIOFACIAL
CENTER of NWA

Diabetes?				Delayed development?		
Are you on dialysis?				Osteoporosis/		
Kidney trouble?				Other problems not		
Allergies (food/ medicine)? Please List:				Surgery? Please List:		

Is there any additional information you would like us to know?_____
_____
_____

I understand that the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

*Patient/Guardian's Signature: _____ Date:_____

CLEFT and CRANIOFACIAL
CENTER of NWA

PATIENT INFORMATION

Date _____
Last Name_____
First_____ M.I. _____
Prefers to be called by: _____
Race/Ethnicity/Nationality:_____
Address:_____
City_____ State____ Zip_____
Home Phone No. _____
Cell Phone No._____
Circle one:
Married Single Widowed Divorced
Social Security Number_____
Email Address_____
Occupation_____
Employer's Number_____
Address_____
City_____
Phone No. _____Fax No._____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE
Name_____
Relationship to Patient_____
SSN_____ Address:_____
City_____ State____Zip_____
Phone No. _____Fax No. _____
Cell No. _____Email_____
Occupation_____
Employer's Number_____
Address_____
City_____
Phone No. _____Fax No._____

Primary Insurance :_____
Policy Holder Name:_____
Policy ID: _____
Group #:_____
Secondary Insurance :_____
Policy Holder Name:_____
Policy ID:_____
Group #:_____

FAMILY INFORMATION

Is another member of your family or relative a patient at our office?
Name_____
Relationship_____
Person to contact for emergency_____
Phone Number_____
Address_____
City_____ State_____ Zip _____
Closest relative not living with you_____
Phone No. _____
Address_____
City_____ State_____ Zip_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other

diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient) _____'s needs.

Date_____ Witness_____

2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient/Guardian Signature:

_____

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may provide you with a report of your progress for your insurance company if applicable.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may provide you with appointment reminders such as postcards and/ or a phone call. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. If this practice is sold, your information will become the property of the new owner.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may

or may not make the changes your request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

ACKNOWLEDGEMENT (Please note: You may refuse to sign this acknowledgement)

I have received a copy of the Notice of Privacy Practices.

Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient _____

Thank you, and if you have any questions about this form or the Privacy Practices, please contact our privacy officer.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representative's) signature on the Acknowledgement but did not because _____ It was emergency treatment, _____ I could not communicate with the patient ___, The patient refused to sign____, The patient was unable to sign because: _____ Other (please describe)

ADVANCE NOTICE FOR CANCELLATION AGREEMENT

Our practice is committed to providing exceptional health care in a timely manner. Due to the nature of a cleft and craniofacial center, a significant number of our patients present with comprehensive medical and/or dental problems, which dramatically affect their quality of life. It is our mission to improve these situations with, proper conscientious care. Therefore, it is very important that we respect all scheduled appointments. These appointments are considered confirmed at the time they are made. We will call you one, as a courtesy, to remind you of the appointment. Because a substantial amount of time has been set aside for you, we will charge $50 per hour for appointments missed with the doctor. Please contact the office two business days in advance, if you need to reschedule, to avoid this charge.

Thank you for your understanding in this matter.

Signature of patient or responsible party: _____ Date: _____

Office hours: Monday-Friday 8:00-5:00

CLEFT and CRANIOFACIAL
CENTER of NWA

Patient Bill of Rights

You have the right:

- To safe, considerate and respectful care, provided in a manner consistent with your beliefs.
- To expect that all communications and records pertaining to your care will be treated as confidential to the extent permitted by law.
- To know the physician responsible for coordinating your care at the Cleft and Craniofacial Center of NWA.
- To receive complete information about diagnosis, treatment, and prognosis from the physician, in terms that are easily understood. If it is medically inadvisable to give such information to you, it will be given to a legally authorized representative.
- To receive information necessary for you to give informed consent prior to any procedure or treatment, including a description of the procedure or treatment, any potential risks or benefits, the probable duration of any incapacitation, and any alternatives. Exceptions will be made in the case of an emergency.
- To receive routine services when hospitalized at the Cleft and Craniofacial Center of NWA in connection with your protocol. Complicating chronic conditions will be noted, reported to you, and treated as necessary without the assumption of long-term responsibility for their management.
- To know in advance what appointment times and physicians are available and where to go for continuity of care provided by the Cleft and Craniofacial Center of NWA.
- To receive appropriate assessment of, and treatment for, pain.
- To refuse to participate in research, to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of these actions, including possible dismissal from the study and discharge from the Cleft and Craniofacial Center of NWA. If discharge would jeopardize your health, you have the right to remain under Cleft and Craniofacial Center of NWA care until discharge or transfer is medically advisable.

- To be transferred to another facility when your participation in the Cleft and Craniofacial Center of NWA study is terminated.
- To expect that a medical summary from the Cleft and Craniofacial Center of NWA will be sent to your referring physician.
- To designate additional physicians or organizations at any time to receive medical updates

3394 N Futrall Drive, Suite 2
Fayetteville, Arkansas 72703
(800) 476-7131

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

PRINTED NAME: _____ DATE: _____

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Cleft and Craniofacial Center of NWA's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment of both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Expiration – 3 years from Initial Signature; Insurance Change; Patient reaches age of 18

I consent for the Cleft and Craniofacial Center of NWA to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone

_____ / _____ / _____

_____ / _____ / _____

Signature: _____

☐Patient ☐ Parent ☐ Guardian / Other

CLEFT *and* CRANIOFACIAL
CENTER *of* NWA

Release of Information

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. **PROCESS ALL INSURANCE CLAIMS.**
2. **ENSURE PAYMENT FOR SERVICES PROVIDED.**
3. **RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS.**
4. **RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.**
5. **RELEASE INFORMATION TO OTHER PROFESSIONALS AS NEEDED, INCLUDING SCHOOLS, EMPLOYER, OR ADDITIONAL AGENCIES AS SPECIFIED BY THE PATIENT/CAREGIVER.**

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary to other providers rendering care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to Dr. Taylor, Dr. Storms, Torry Farnell, and Cleft and Craniofacial Center of NWA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Date of Birth: _____

Patient Full Name (printed): _____

Patient Signature: _____

Caregiver Signature (If applicable):_____

Witness: _____

Date Signed: _____

CLEFT *and* CRANIOFACIAL
CENTER *of* NWA

PHOTOGRAPHY/IMAGING CONSENT FORM

I consent for medical imaging (photo, video, radiographic images and/or audio) to be made of **myself** or **my child** (or for person whom I am legal guardian). I understand that the information from my medical records may be used for purposes of teaching, publication, or marketing, advertising, and media (including websites, printed materials, news reporting, documentary films, commercials, television or film, social media, websites, etc.).

By consenting to this, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recording will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the staff at Cleft and Craniofacial Center of NWA.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

_____ _____

Patient/ Guardian Signature: Date:

_____

Printed Name:

MEDICAL RELEASE FORM

I,_____ , (**DOB / /**), give my consent for my medical and dental records to be shared with the providers at Cleft and Craniofacial Center of NWA.

Please consider this request to be effective immediately.

Signature _____ Date _____

3394 N. Futrall Dr., Suite 2
Fayetteville, AR 72703

(800) 476-7131

hello@cccofnwa.com