THE INSTITUTE OF FACIAL SURGERY

LANCE F. GRENEVICKI, DDS, MD, FACS

Oral and Maxillofacial Surgery • Facial Cosmetic Surgery

1093 South Wickham Road • West Melbourne, Florida 32904 • (321) 674-3900 • Fax (321) 722-3303

PATIENT REGISTRATION

Date_____

Patient's Name_____ Sex_____

Social Sec. #_____ Birth Date_____ Age_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Business Phone_____ Cell Phone_____

Place of Employment_____ Address_____ Occupation_____

Name(s) of Spouse or Parents_____ Social Sec. #_____

Place of Employment of Spouse or Parents_____ Business Phone_____

Emergency Contact Name_____ Phone_____

Who referred you to the office?_____

Family Dentist's Name_____ Family Physician's Name_____

Have you ever been a patient in our office?_____ When?_____

E-mail Address_____

INSURANCE INFORMATION

1st Dental Insurance	**Medical Insurance**
Company_____	_____
Policy Holder (Employee)_____	_____
Group/Policy Number_____	_____
Certificate or ID Number_____	_____
Policy Holder's Social Sec. #_____	_____
Policy Holder's Date of Birth_____	_____
Address of Insurance Company_____	_____
_____	_____

2nd Dental Insurance	**Medical Insurance**
Company_____	_____
Policy Holder (Employee)_____	_____
Group/Policy Number_____	_____
Certificate or ID Number_____	_____
Policy Holder's Social Sec. #_____	_____
Policy Holder's Date of Birth_____	_____
Address of Insurance Company _____	_____
_____	_____

All professional services provided are charged to the patient. Necessary forms will be completed to expedite insurance carrier payment. The patient (or parent, if minor child) is responsible for all fees, regardless of insurance coverage. It is expected that all fees will be paid at the time of services unless other arrangements have been made in advance. Duplication of x-rays and copying of records require 10 business days for a cost of $15.00.

CONSENT FOR USE OF PHOTOGRAPHS OR IMAGES

I hereby grant permission for the use of any illustrations, photographs, or imaging records, for the limited and specific use of same in scientific and professional publications, journals and presentations at any time following my treatment.

_____ YES _____ NO *(Please Initial)*

FINANCIAL RESPONSIBILITY/INSURANCE AUTHORIZATION

I authorize the release of any medical/dental and personal information necessary for my treatment and processing of insurance claims if applicable to necessary physicians, hospitals, laboratories and family members. I also request payment of government/private insurance benefits to the doctor. I understand that I am responsible for my total bill, including any portion of those charges not covered by my insurance plan, i.e. hazardous waste, etc.

Date_____ Signature_____

(If patient is a minor, parent or legal guardian must sign)

*Patient Name:*_____ *Dr. Grenevicki*

(CIRCLE EACH ONE) **HEALTH QUESTIONNAIRE**

YES NO 1. Are you currently, or have you been under the care of a physician or hospitalized in the past 2 years? If so, for what reason? _____

YES NO 2. Please list any drugs, medications, pills (including birth control) you are taking: _____

YES NO 3. Are you allergic to anything: Penicillin, drugs, Medications? Please list:_____

YES NO 4. Have you ever had any other adverse drug reaction? Please list:_____

YES NO 5. Have you taken cortisone or other steroid drugs? Please list:_____

6. Have you had any of these immunizations: Herpes Zoster (shingles)_____ Tetanus_____ Flu_____ Measles_____ Mumps_____ Rubella_____ Covid-19_____ Covid Booster _____

7. Have you ever had any of the following? (Check each box)

YES	NO		YES	No		YES	NO	
☐	☐	Heart Trouble, Arrhythmia	☐	☐	Porphyria	☐	☐	Emphysema, Bronchitis
☐	☐	Heart Attack	☐	☐	Cancer or Tumor	☐	☐	Asthma
☐	☐	Chest Pain	☐	☐	Stroke	☐	☐	Hay Fever
☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Sinus Problem
☐	☐	Circulation Problem	☐	☐	Kidney/Bladder Problem	☐	☐	Covid-19
☐	☐	Heart Murmur	☐	☐	Epilepsy	☐	☐	Hepatitis, Liver Condition
☐	☐	Rheumatic Fever	☐	☐	Psychiatric Treatment	☐	☐	Excessive Bleeding
☐	☐	Thyroid Condition	☐	☐	Fainting	☐	☐	Herpes, Cold Sores
☐	☐	Anemia, Sickle Cell	☐	☐	Glaucoma	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Ulcer, Stomach Trouble	☐	☐	HIV

YES NO 8. Have you had any other serious illness? Please list:?_____

YES NO 9. Do you have any family history of disease?_____

YES NO 10. (Women) Are you pregnant? How many months?_____

YES NO 11. Have you ever had any operations? Please list:_____

YES NO 12. Have you ever been on any bisphosphonate (Actonel, Boniva, Fosamax, Zometa, Reclast)? How long?_____

YES NO 13. Have you ever had any problem with local or general anesthesia? Please describe:_____

YES NO 14. Do you smoke? Packs per day?_____Do you vape?_____

YES NO 15. Alcohol/Drugs?_____

YES NO 16. Are you wearing contact lenses?_____Dentures?_____

YES NO 17. Have you had anything at all to eat or drink in the last 6 hours?_____

I hereby certify that the answers I have given on this questionnaire are true and correct to the best of my knowledge. This office is a surgery center regulated pursuant to the rules of The Board Of Medicine as set forth in rule Chapter 64B8, F.A.C.

DATE_____ Signature_____
(Patient's Signature))

DATE_____ Signature_____
(Physician's Signature)

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Diplomate of the American Board of Oral & Maxillofacial Surgery — *Fellow, American Academy of Cosmetic Surgery*

Fellow, American Association of Oral & Maxillofacial Surgeons — *Fellow, American College of Surgeons*

POLICY OF THE INSTITUTE OF FACIAL SURGERY

Welcome to the Institute of Facial Surgery and thank you for choosing us to provide your oral and maxillofacial surgery care. We would like to familiarize you with our office and the services we provide. We strive to provide our patients with quality surgical care. As an oral and maxillofacial surgeon, Dr. Grenevicki manages a wide variety of problems relating to the mouth, teeth and facial regions. Wisdom teeth removal and the removal of infected and non-restorable teeth are just one aspect of our service, while many other surgical services are available. These include the placement of dental implants, correction of developmental facial deformities (abnormal jaws, chin), treatment of facial trauma (jaw and facial fractures and facial lacerations), preparation of the mouth for dentures, treatment of pathology (biopsies and tumors), reconstructive surgery, and TMJ treatment. In addition to these services facial cosmetic procedures are also available including Botox, Restylane, Collagen injections, Facial peels, Laser Resurfacing and Cosmetic surgery. Many of these procedures can be safely and effectively completed in our office using state of the art pain control techniques including local anesthesia, conscious sedation, and general anesthesia. Occasionally, for more complex cases, treatment requires hospitalization. We are on the medical staff of several area hospitals.

Payment is expected at the time services are performed. Please note surgical cases must be paid in advance. We accept cash, checks, Visa, and MasterCard. Payment arrangements are also available through Care Credit for those who qualify. As a courtesy we will file your insurance for you, but you will be responsible for all applicable payments at the time of your visit. Please keep in mind that you are fully responsible for your total obligation should your insurance benefits result in less coverage than anticipated. Your insurance policy is an agreement between you and your insurance company, not between your insurance company and our office. Refund checks will be issued approximately 90 days upon receipt of final insurance payment. There is a $10.00 personal protection equipment fee and a $ 65.00 – 75.00 surgical/anesthesia tray fee which will be the patient responsibility.

Please give proper 2 days notice if you need to cancel or reschedule your appointment to avoid a $50 cancellation fee.

Choice of Law/Venue: This Agreement shall be governed by the laws of the State of Florida and venue for its enforcement shall lie exclusively in Brevard County, Florida.

Attorney's fees: If any action is filed or initiated to enforce any of the provisions of this Agreement, or this Agreement is turned over to collection agency or an attorney for collection, whether or not suit is initiated, the prevailing party shall, in addition to all other relief to which they are otherwise entitled, be entitled to recover all costs, expenses and reasonable attorney's fees (including paralegal fees), at both trial and all appellate levels, from the unsuccessful party.

Waiver of trial by jury: Both parties waive trial by jury in any action or proceeding brought by either party against the other on any matters whatsoever concerning this agreement.

We look forward to meeting your oral and facial care needs. **On day of surgery, we accept cash, money order or credit card. Any payment with check will need to be 10 business days in advance.**

_____ _____

(Signature) I have read and agree to the above policies of The Institute of Facial Surgery *Date*

Patient Name:_____

I_____hereby acknowledge that I have received a copy of this practice's Notice of Privacy. I have been given the Opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature *Date*

**** Original Privacy Notice page 1-2 given to patient for their records.***

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NOTICE OF PRIVACY PRACTICES

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.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of uses of your health information for payment purposes: We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Uses of Your Information for Health Care Operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights: The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office at 321-674-3900 in writing or via telephone, during normal hours. We will provide you with assistance on the steps to take to exercise your rights

Our Responsibilities the practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provision regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint: If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Pam, our Compliance Privacy Officer at 674-3900.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint to our office. You may also file a complaint by mailing it to the Secretary of Health and Human Services, to which we may file a rebuttal.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification: Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defect, or post-marketing surveillance information to enable product recalls, repairs, or replacements

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health: As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect: We may disclose your protect health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protect health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight: Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses: Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization in writing.

Effective Date: April 14, 2003