SOUTHEASTERN PENNSYLVANIA ORAL SURGERY

EPISCOPAL HOSPITAL
100 E. Lehigh Avenue
Philadelphia, PA 19125
(215) 707-3613

PLEASE PRINT **FAVOR DE ESCRIBIR**

Patient Name _____ Social Security Number _____
Nombre del Paciente *Número del Seguro Social*

Date of Birth _____ Sex: Male_____ Female _____ Mother's First Name _____
Fecha de Nacimiento *Sexo: Hombre* *Mujer* *El Primer Nombre de su Madre*

Street Address _____ Telephone (home) _____
Dirección Residencial *Número de teléfono (casa)*

City _____ State_____ Zip _____ Apartment # _____
Ciudad *Estado* *Zona* *Número del Apartmiento*

Marital Status: Single/*Soltera* ❑ Married/*Casado/a* ❑ Widowed/*Viuda/o* ❑ Separated *Separada/o* ❑ Divorced/*Divorciada/o* ❑

Emergency Contact: _____ Telephone: _____
Persona de Emergencia *Número de teléfono*

Employer: _____ Telephone (work): _____
Cito de Empleo *Número de teléfono (trabajo)*

Employer's Address: _____ City: _____ State: _____ Zip: _____
Dirección del empleo *Cuidad* *Estado* *Zona*

Referring Physician: _____ Address: _____
Se refiere del Médico *Dirección*

Referring Dentist: _____ Address: _____
Se refiere del Dentista *Dirección*

INSURANCE INFORMATION ~ INFORMACIÓN DEL SEGURO MÉDICO		
Primary - *Primario*	**Secondary - *Segundario***	**Dental Insurance - *Seguro del Dentista***
Insurance Company: *Compañia del Seguro Médico*	Insurance Company: *Compañia del Seguro Médico*	Insurance Company: *Compañia del Seguro Médico*
Subscriber: *Persona Inscrita*	Subscriber: *Persona Inscrita*	Subscriber: *Persona Inscrita*
Policy # *Número de la Polisa* Group # *Número de Grupo*	Policy # *Número de la Polisa* Group # *Número de Grupo*	Policy # *Número de la Polisa* Group # *Número de Grupo*
Plan # *Número del plan* Co-payment: *Co-pago*	Plan # *Número del plan* Co-payment: *Co-pago*	Plan # *Número del plan* Co-payment: *Co-pago*
Insurance Address *Dirección del Seguro Médico*	Insurance Address *Dirección del Seguro Médico*	Insurance Address *Dirección del Seguro Médico*
City, State, Zip *Ciudad, Estado, Zona*	City, State, Zip *Ciudad, Estado, Zona*	City, State, Zip *Ciudad, Estado, Zona*
Telephone Number: *Número de Teléfono*	Telephone Number: *Número de Teléfono*	Telephone Number: *Número de Teléfono*

if the patient is a minor/dependent child, or if the subscriber is someone other than the patient, please complete this section of the form.
Si el paciente es un niño, o si la persona inscrita es otra que no sea el paciente, necessita favor de completar esta sección de la forma.

Mother's/Subscriber/Guarantor's Name (last, first) *Nombre de su madre (apellido, primer nombre)*	Father's Name (last, first) *Nombre de su padre (apellido, primer nombre)*
Relationship *Relación*	Relationship *Relación*
SS# *Número del Seguro Social* Date of Birth *Fecha de Nacimiento*	SS# *Número del Seguro Social* Date of Birth *Fecha de Nacimiento*
Address: *Dirección*	Address: *Dirección*

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To our patients:
Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit _____

_____

A.

		YES	NO
1.	Are you in good health? ..... Height _____ Weight _____	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ..... Date of last visit: _____ If so, for what are you being treated? _____	❑	❑
4.	Have you had any illness, operation or been hospitalized in the past five years? _____	❑	❑
5.	Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth? ..... If so, describe where _____	❑	❑

B.

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES
1	Rheumatic fever?				21	Convulsions, epilepsy?			
2	Damaged heart valves/ mitral valve prolapse?				22	Stroke?			
3	Heart murmur?				23	Thyroid trouble?			
4	High/low blood pressure?				24	Diabetes / low blood sugar?			
5	Chest pain, angina?				25	Kidney trouble?			
6	Heart attack(s)?				26	Are you on dialysis?			
7	Irregular heart beat?				27	Urinary problems?			
8	Cardiac pacemaker?				28	Contagious diseases / Sexually transmitted diseases?			
9	Heart surgery?				29	AIDS or HIV infection?			
10	Bronchitis, chronic cough?				30	Problems of the immune system?			
11	Hayfever / Sinus problems?				31	Mental health problems?			
12	Asthma / Chronic lung disease?				32	Are you wearing a removable dental appliance?			
13	Do you smoke?				33	Habit-forming drugs?			
14	Blood transfusion?				34	Alcohol beverages?			
15	Blood disorder such as anemia?				35	Contact lenses?			
16	Bruise easily?				36	X-Ray treatment / chemotherapy?			
17	Bleeding tendency (abnormal bleed?)				37	Pain & clicking of jaws when eating?			
18	Jaundice, hepatitis or liver disease?				38	Malignant Hyperthermia?			
19	Blood clots?								
20	Fainting spells?								

TDS-1 Rev. 2/12

Name _____ D.O.B. _____ Date _____

C.	MEDICATIONS	YES	NO
1.	**ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?**	❑	❑
2.	Anticoagulants?	❑	❑
3.	Tranquilizers?	❑	❑
4.	Cortisone?	❑	❑
5.	Other medications? (Please list)	❑	❑

D.	ALLERGIES	YES	NO
1.	**ARE YOU ALLERGIC TO OR HAD A REACTION TO LOCAL ANESTHETICS?**	❑	❑
2.	Penicillin?	❑	❑
3.	Other antibiotics?	❑	❑
4.	Sodium pentothal, Valium, or other tranquilizers?	❑	❑
5.	Aspirin?	❑	❑
6.	Codeine or other narcotics?	❑	❑
7.	Other medications?	❑	❑
8.	Allergies other than drug allergies? (Please list)	❑	❑

E.	**IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?**	❑	❑

F.	**WOMEN:**		
1.	Is there a possibility that you may be pregnant?	❑	❑
2.	Estimated delivery date?	❑	❑
3.	Are you nursing?	❑	❑
4.	Are you taking birth control pills?	❑	❑

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecololgist for assistance regarding additional methods of birth control.

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

Signature of patient: _____ Date: _____
(Parent or Guardian if minor)

TDS-1A Rev. 5/11

Name _____ D.O.B. _____ Date _____

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(215) 707-5405 Fax

Consent for Treatment and Authorization to Pay Benefits

Consent for Treatment:
I hereby generally consent to the rendering of care, which may include routine diagnostic and therapeutic procedures, as the attending physician and such associate assistants and other health care providers deem necessary.

I understand that:
A) It is customary, except in case of an emergency or extraordinary circumstances, that no surgical or invasive procedures are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional.
B) Each patient has the right to consent; or to refuse consent, to any procedure without his/her full knowledge and consent. I understand the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of examination or treatment in this office.

Authorization to Pay Benefits:

Medicare Patients

I request that payment under the medical insurance program be made to Southeastern Pennsylvania Oral Surgery, LLC, on all future bills for services rendered to me by Southeastern Pennsylvania Oral Surgery, LLC. I authorize Southeastern Pennsylvania Oral Surgery, LLC to release to the Health Care Financing Administration, or such other secondary payors and their agents, any medical information needed to determine these benefits, or the benefits payable to related services.

Commercial Insurance Patients

I authorize that any insurance benefits for services and/or medical care rendered by Southeastern Pennsylvania Oral Surgery, LLC, or its designees be released by the insurance carriers or others who are financially liable for services and/or medical care, to Southeastern Pennsylvania Oral Surgery, LLC, or its designee all medical records and other information needed to substantiate payment for such. I also authorize Southeastern Pennsylvania Oral Surgery, LLC or its designee, to release to Insurance carriers or others who are financially liable for services.

Payment Guarantee

I, and the undersigned agree to assume full financial responsibility, and to personally guarantee payment of all charges hereafter incurred at Southeastern Pennsylvania Oral Surgery, LLC, and not paid for by third party payors. This payment is expected to be made within 30 days of notification of any balance not paid by the third payors. I understand that if this bill is not paid within this period of time, that the account may be turned over to the designated collection agency.

I certify that I have read and fully understand the above.

Patient/Guarantor Signature	Date
Guardian/Next of Kin Signature	Relationship
Witness	

SOUTHEASTERN PA ORAL SURGERY, LLC

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
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.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice effective April 14, 2003. We do reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you may be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records
- Diseases spread person to person
- Drug and or alcohol abuse
- Medical History
- Treatment in progress
- Any other related facts

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management
3. Any personal care facility where you live
4. Any other doctor providing your care
5. Family members and other people who are part of your plan for service
6. State and Federal agencies acting on behalf of programs such as Medicare or Medicaid
7. Other health care people to start treatment

We may contact you via telephone, postcard or other mailings to:

1. Provide appointment reminders
2. Discuss issues involving payments on your account

We may use a sign-in sheet for:

1. The purpose of keeping track of patients that are being seen on a daily basis. This sheet is destroyed at the completion of each day.

We may take photographs to:

1. Use for decisions made in dental treatment
2. Posting within our offices for the purpose of showing the progression of treatment

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment
2. Where significant barriers to communication with you exist and we determine that the consent is clearly inferred from the situation
3. Where we are required by law to obtain treatment and we are unable to obtain consent
4. For certain public health activities, such as reporting injuries, death, diseases, etc.
5. Where the use or disclosure is required by law
6. Where we reasonably believe you are a victim of abuse, neglect or domestic violence
7. To coroners, medical examiners and funeral directors
8. For certain research purposes
9. For Workman's Compensation purposes
10. For specialized government functions, including custodial situations

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules)
2. To a family member, friend or other person you choose, who may assist in your care or payment for care

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you; however, we are not required to agree to the requested restrictions
2. Receive confidential communication by giving us another address
3. Inspect and receive a copy of protected health data by filling out our request form

4. Receive a list of disclosures made of your protected health data by filling out our request form
5. Amend protected health data by filling out our request form
6. Obtain a copy of this notice at any time

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact:

Carol Martin, HIPAA Compliance Officer
Southeastern PA Oral Surgery, LLC

Temple University Hospital
Eiscopal Division
100 E. Lehigh Avenue
Philadelphia, PA 19125
(215) 707-3613

ACKNOWLEDGEMENT

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I hereby certify that I have received a copy of Southeastern PA Oral Surgery, LLC notice of Privacy Practices.

_____ ____/____/____
Printed Name of Recipient Date

_____
Signature of Recipient

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from the above referenced individual, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____

_____

_____

ABOUT THE HIV ANTIBODY TEST

ue as HIV?
virus de inmunodeficiencecia humana, HIV, es el virus que causa el Simdrome de munodeciencecia Adquirida (SIDA). El virus de inmunodeficiencecia humana causa DA al atacar elsistema inmunologico, el cual es responsibable de contrarestar fecciones y canceres. Cuando alguien se infecta co HIV, el cuerpo fabrica una ibstancia dirigida a contrarestar el virus, llamada anticuerpos.

ue es un anitcuerpo de HIV?
nticuerpos son sustancias químicas fabricades por el sistema immunadaco para ombater las infecciones, para ayudar al cuerpo a recuperarse y en algunos prevenar gundos episodios de infeccion con el mismo microbio. En el casa de humano un itcuerpo es formado no es elective en conbatir el virus. La prueba de sangre que usted ta a punto de hacerse, busca por la presencia de estos anticuerpos en la sangre.

omo se infecta alguien con SIDA?
SIDA se encuentra en al snagre y en cierntos fluidos del cuerpo de personnas ienes estan infectadas con el virus. Por ejemplo, el SIDA se propaga de una persona fectada a otra a traves del contacto sexual. Otros medios de trasmicion incluyen, el uso e jennguilas contaminadeas con la sangre de un individio infectado, es decire, cuando os drogadictos comparten el uso de la misma jennguilta. El SIDA es tambien ansmitido al bebe en cieto porcentaje por mujeres embarazadasinfectadas con el virus traves del cordon umbilical, o por la leche de la mama. Algunas personas han sido fectadas por la transfusion de sangre contamindada oproductos derivados de sangre ntes de la primavera de 1985. cuando se comenzo a examiner todas las donaciones e sangre en losEstado Unidos. Sin embargo, ahora es extremadamente dificl adquier virus por transfusions de sangre on los Estado Unidos. El SIDA no se propaga por ontacto casual tal como, hablar or tocar. No es propagado por insectos. No es ropagado al senatarse en un inordoro, por el uso del telefono, o otras objectos del ogar.

omo puedo ser ifectado con EL SIDA si yo me siento bien?
a mayoria de las personas que estan infectadas con el SIDA. se ven y sientien erfactamente bien. Amenuedo toma aproximadament diez anos o mas cara que una ersona infectada se empiece a sentir enferma ha causa de esto. El SIDA puede ser ansmitido a otra persona por alguien que no tiene sintoma alguno.

ue significa un "examen positive"?
robablemente significa que usted ha sido infectado con SIDA. Sin embargo, hay una portunidad pequena de que los resultados sean incorrectos. SI usted esta infectado, seted puede infectar a otras personas con las cuales usted tiene sexo ocomparte gujas. Si las prueba es positive, usted sera aconsejado arcerca del significado de lose esultados y lendra tiempo para hacer preguntas. Sera su responsibilidad informar a las ersonas a las que usted ha expuesto al virus a traves de contacto sexual o otros nedios. El tener una prueba positive no significa que usted tiene SIDA la expression linica de ser infectado con HIV. El Sida es diagnosticado usando un numero de initenos y otras medios en adicion a la preuba de sangre. Una prueba consitiva no ndica o pronostica cuando o si algua vez usted desarrollara SIDA. Solamente indica xposicion al virus, y muy probablemente, la existencia continus del virus en su cuerpo.

ue significa un "examen negative"?
ignifica que usted probablement no esta infectado con SIDA. Sin embargo, Toma al istema inmunologico semanas o meses para desarrollar un anticuerpo para el SIDA. sto significa si usted fue espuesto y infectado recientemente, puede que todavia seted no este fabricando suficientes anticuerpos para nosotros poder medinos. Asi es ue, aunque se prueba es negative, hay una oprtunidad pequena de que rest infectado i se ha expuesto a los nesgas antes mencionados. Si usted ha sido recientemente nfectado con el SIDA pero aun tiene una prueba de anticuerpos negative, used sera iconsejado acerca del significados de la prueba y usted lendra tiempo de hacer mas preguntas.

ue sucede con las resultados del exam?
oma los resultados de otras pruebas de sangre, el resultado de los anticuerpos del IDA pasen a ser parte permanente de su historial medico. El resultado estara disponible ara las personas que esten encargades da su salud. Toda la informacion de su historial nedico es confidencial, pero estara disponible para aquelias personas a quien usted a lado un permiso escrito de lener acceso al mismo. En algunas circumstancias esto uede incuir su companies de seguro, medico, o su patron. Puede que tambien otras ersonas pueden obtener su historial medico con una orden de la corte. La coaret puede ambien porveer con protection apropriada. Para tener acceso a escrito. Si usted teine ecuro medico, por incapacidad, or seguru de vida, quizaz a un cundo no reuerde el acerlo,. useted firno una forma dando permiso a l companie de obtenersu hostrial nedico. Pruebes confidenciales de anticuerpos de SIDA tamvien son hechas por las CURUZ ROJA AMERICANA y otras clinicas y facilidades de salud pub;ica. Aunque esultados positivos tienen que ser reportados al Departmento de Salud del estado de ennsylvania, estos resultados no formaran parte de su historial medicao en es outheastern Pennsylvania Oral Surgery. En adicion, el Departamento Salud del Estado de Pennsylvania ofrece un numero limitado de lugares donde se hances pruebas anonimas de anticuerpos de SIDA. Si usted elige esta opcion, usted es la unica persona que conocera los resultadod se su pruebe de anticuerpos. Usted debe estar enterado de que si su medico la diagnostica que tiene HIV o SIDA, la ley require que su nombre y el didagnostico sean reportados al Departamento de Salud del Estado de Pennsylvania.

Donde puedo obtener mas informacion o el examen de anticuerpos HIV?
El primer recurso de informacion debe ser su medico. En adicion, usted o su medico pueden liamar el Coordinador del SIDA del hospital. Puede que usted desee ademas liamar a lina del SIDA en Pennsylvania al telefono 1-800-232-4636

What is HIV?
Human immunodeficiency virus, HIV, is the virus that causes the acquired immunodeficiency syndrome (AIDS), HIV causes AIDS by attacking the immune system, which is responsible for fighting against infections and cancers, When someone is infected with HIV, the body makes a substance directed against the virus, called an antibody.

What is a Human Antibody?
Antibodies are chemical substances made by the body's immune system to fight infections, to help the body recover and in some cases prevent second episodes of infection with the same germ, In the case of HIV, even though an antibody is formed, it is not effective in fighting the virus, The blood test you are about to have looks for the presence of these antibodies in your blood.

How does someone get infected with HIV?
HIV is found in the blood and certain body fluids of people who are infected with the virus, For example, HIV is spread from an infected person to another person by sexual contact, by sharing needles when injecting heroin or other non-medical drugs, or from an infected pregnant woman to her baby while it is still in the uterus or at birth. The virus may also be spread through the milk of a breast-feeding mother. Some people were infected by transfusions of infected blood-to-blood products before Spring 1985, when testing of alt blood donations began in the United States. However, it is now extremely unlikely to be spread by blood transfusions in the United States. HIV is not spread by casual contact such as talking or touching. It is not spread by insects. It is not spread by toilet seats, telephones, or other household objects.

How can I be infected with HIV if I feel fine? Most people who are infected with HIV look and feel perfectly well. It often takes ten years or even longer before an infected person begins to feel sick, HIV can spread to other people from someone who has no symptoms at all.

What does a "positive test" mean?
It most likely means you have been infected with HIV. However, there is a small chance that the results are incorrect. If you are infected, you can infect other people with whom you have sex or share needles. If the test is positive, you will be counseled about the meaning of the results and you will have time to ask more questions. It will be your responsibility to inform the people you. have exposed to the virus through

Having a positive test does not mean that you have AIDS. AIDS is diagnosed using a number of other means and. criteria in addition to the blood. test. . A positive test does not indicate or predict when or if you will ever develop AIDS. It only indicates exposure to the virus; and most likely, the ongoing existence of the virus inside your body.

What does a "negative test" mean?
It means that you are probably not infected with HIV. However, it takes the body's immUne system weeks or months to develop an antibody to HIV. That means if you were exposed and infected recently, you might not yet be making enough antibody for us to be able to measure it. So even if your test is negative, there is a small chance that you are infected. If you recently have been infected with HIV but still have a negative antibody test, you can still transmit it to other people. If your test is negative you will be counseled about the meaning of a negative test and will have time to ask more questions.

What happens to my test results?
Like the results of other blood tests, the HIV antibody result becomes a permanent part of your hospital record. The result will be available to those health care workers who are taking care of you or involved in medical education. All information in your chart is confidential. but it can be made available to those people to whom you give written permission for access to your chart. In some circumstances, that may include your medical insurance company or employer. If may also be possible for others to obtain your record with a court order. The court may also provide for appropriate safeguards.

Most insurance policies require you to sign permission for them to have access to your medical record. If you have medical disability, or life insurance, you probably signed a form giving the company permission to look at your records, even if you do not remember doing so.

Confidential HIV antibody testing is also performed by the American Red Cross and other clinics and health care facilities. Although positive results must be reported to the State Department of Health, those results will not be a part of your medical records at Cooper Hospital. In addition, the New Jersey Department of Health offers a limited' number of sites where anonymous HIV antibody testing is performed, If you choose that option. you are the only person who will know the results of your antibody test.

You should be aware that if your doctor diagnosis you as having HIV infection or AIDS, the law requires that your name and diagnosis be reported to the Pennsylvania Department of Health.

Where can I get more information about AIDS or the HIV antibody test?
The first resource for information should be your doctor. In addition, you or your doctor may contact the. hospital's AIDS Coordinator, You may also wish to call the Pennsylvania AIDS Hotline at 1-800-232-4636

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Consent for Infectious Disease Testing in Event of a WORKER EXPOSURE INCIDENT

To comply with Federal OSHA regulations, Southeastern Pennsylvania Oral Surgery requests that patients give consent to infectious disease testing, including Human Immunodeficiency Virus (HIV) and Hepatitis, in the event of an Exposure Incident so that results may be made available to an exposed individual, including Hospital employees, physician staff and/or EMS workers.

An Exposure Incident, pursuant to 29 C.F.R. §1910.1030 means a specific eye, mouth, other mucous membrane, non-intact skin, or potential contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

I understand that by signing this consent form, I will not be tested for infectious diseases, including HIV, unless an Exposure Incident has occurred. If I am tested for an Exposure Incident I will not be charged for the testing. In the event of another reason for HIV testing, such reason will be explained to me and a separate consent form will be provided to me.

I understand that I am not required to sign this consent to obtain treatment at Southeastern Pennsylvania Oral Surgery. If I decline to sign this consent, I shall not suffer adverse consequences or discrimination in treatment and shall not be refused treatment based on declining to sign this consent.

I have been provided the patient information sheet entitled "About the HIV Antibody Test" (on the back of this form) which provides risks, benefits and limitations of the test and I have had the opportunity to ask questions and any questions have been answered. I understand the limitations of the test and that results may occasionally indicate that a person has antibodies to the virus when the person does not (false positive) or it may fail to detect that a person has antibodies to the virus when the person has the virus (false negative).

I know that having a positive test does not mean that I have AIDS. Other means must be used in conjunction with the blood test to make that diagnosis. I also know that if I am found to be infected with HIV, the law requires that my name be reported to the Pennsylvania Department of Health.

I understand that if a test is performed, it will be my decision whether to seek further evaluation or treatment based on the results provide to me. I also understand that I will continue to receive medical care for the condition(s) which resulted in my hospitalization, regardless of the test results. I am also aware that there are other options to be tested for HIV or Hepatitis with my consent, including, in the case of HIV, confidential and anonymous testing which can be done outside of Southeastern Pennsylvania Oral Surgery.

My signature below means that I give Southeastern Pennsylvania Oral Surgery permission to test for infectious diseases, including HIV and Hepatitis, in the event of an Exposure Incident and to disclose the results of the test to the exposed individual and their treating physician for purposes of treatment.

I further understand that I may revoke this consent at any time except to the extent that Southeastern Pennsylvania Oral Surgery has already acted in reliance on it in disclosing information to an exposed individual.

This consent shall expire 30 days after the day of discharge from Southeastern Pennsylvania Oral Surgery.

_____
Signature of Patient or Representative

_____
Name of Patient

_____
Date

_____
Witness
*This consent form may be signed by the parent guardian, spouse or other duly authorized representative if the patient is unable to sign the form.

_____
Printed name of representative

_____
Relationship to Patient

_____
Reason for substituted consent

I decline to consent to testing n_____ (initials)

I revoke consent to testing n_____ (initials)

Consentimiento para Prueba de Enfermedad Infecciosa en Caso de un Incidente en que el Trabajador sea Expuesto a riesgo de infección

En orden a cumplir con las regulaciones Federales OSHA, Southeastern Pennsylvania Oral Surgery requiere que los pacientes den su consentimiento a las pruebas de enfermedades infecciosas, incuyendo el Virus de la Inmunodeficiencia Humana (VIH) y la Hepatitis B (HBV), para en caso de un incidente con riesgo de infección los resultados puedan ser puestos a disposición del individuo expuesto, incluyendo empleados del Hospital, personal médico y/o trabajadores del Servicio de Emergencia Médica (EMS por sus siglas en inglés).

Un Incidente con riesgo de infección, según 29 C.F.R. 1910.1030 significa en especifico un ojo, boca, otras membranas mucosas, piel no-intacta, o contacto potencial con sangre u otros materias potencialmente infecciosas que puedan resultar del desempeno de las tareas del empleado.

Yo entiendo que al firmar este consentimiento, no seré examiado para pruebas de enfermedades infecciosas, incluyendo VIH, a menos que haya sucedido un incidente con riesgo de infección. Si es que fuese examinado por un incidente con riesgo de infección no pageré nada por la prueba. En el caso que surja otra razón de prueba del VIH, se me explicará tal razón y se me proveerá otro formulario de consentimiento.

Yo entiendo que no estoy requerido de firmar este consentimiento para poder obtener tratamiento en el Southeastern Pennsylvania Oral Surgery. Si es que rehuso firmar este consentimiento, no pasaré consequencias adversa o discriminación en tratamientos y no se rechazará tratamiento en base al rehusar firmar este consentimiento.

Se me ha proveido la hoja de información al paciente titulada "Acerca de la Prueba Anticuerpos VIH" (a espalda de esta forma) que enlista los riesgos, beneficios y limitaciones de la prueba y he tenido la oportunidad de hacer preguntas y cualquier pregunta fue respondida. Yo entiendo las limitaciones del examén y que los resultados puedan ocasionalmente indicar que una persona carga los anticuerpos cuando en verdad no es asi (falso Positivo) o que pueda fallar en detectar que una persona porta los anticuerpos del virus cuando una persona tiene el virus (falso Negativo).

Yo entiendo que el tener una prueba positiva no significa que tengo SIDA. Otros recursos deberán ser utilizados en conjunto con esta prueba de sangre para determinar el diagnóstico. Tambien sé que en caso este infectado con el virus VIH, la ley requiere que mi nombre sea dado al Departamento de Salud de Pennsylvania.

Yo entiendo que si la prueba se lleva a cabo, entiendo que continuaré reciviendo cuidado médico por la condición(es) que resulten en mi hospitalización, a pesar de los resultados de la prueba. También estoy al tanto que existen otras opciones para ser examinado por el VIH o el Hepatitis con mi consentimiento, incluyendo, en el caso del VIH, pruebas confidenciales y anonimas que pueden ser dadas fuera del Southeastern Pennsylvania Oral Surgery.

Mi firma debajo significa que he dado me permiso a Southeastern Pennsylvania Oral Surgery a tomar una prueba para enfermedades infecciosas, incluyendo VIH y Hepatitis, en caso de un Indicidente con riesgo a infección y a revelar los resultados de la prueba a los individuos expuestos y a sus médicos tratantes por motivos de tratamiento.

Yo entiendo también que puedo revocar este consentimiento en cualquier momento excepto en cuando Southeastern Pennsylvania Oral Surgery haya actuado en confianza la misma revelando información al individuo expuesto.

Este consentimiento expirará 30 días después del día de alta de Southeastern Pennsylvania Oral Surgery.

_____
Firma del Paciente o Representante

_____
Nombre del Paciente

_____
Fecha

_____
Testigo
*Este formulario de consentimiento podrá ser firmado por un pariente guardian, cónyuge o un representante debidamente autorizado si es que el paciente es incapáz de firmar el formulario.

_____
Nombre del Representante

_____
Relación al paciente

_____
Razón por consentimiento substituido

n Yo niego dar consentimiento a la prueba

n Yo revoco consentimiento a la prueba _____ (iniciales)