

HAVE YOU HAD ANY SURGERIES? Yes No ** IF YES PLEASE LIST

FAMILY HISTORY

Cancer: Yes No **Diabetes:** Yes No **Heart Disease:** Yes No **Anesthetic Problems:** Yes No **Bleeding Disorder:** Yes No

PERSONAL HEALTH HISTORY

Have you had or do you have:	Yes	No	Notes:	Have you had or do you have:	Yes	No	Notes:
Develop Delay or Autism				Diabetes			
Damage heart valves				Low blood sugar			
Heart murmur				Arthritis or joint disease			
High blood pressure				Osteoporosis/Osteopenia			
Low blood pressure				Stomach ulcers			
Chest pain/angina				Cancer/Radiation			
Heart surgery				Eye disease/surgery			
Heart attack				Delay in healing			
Cardiac pacemaker				Mental Health Issues			
Asthma				Medical Disability			
Hay fever/sinus problems				Blood disorder			
Snoring/sleep apnea				Hepatitis A B C			
Lung problems				Liver Disease			
Tuberculosis/ Emphysema				HIV AIDS STD			
Anemia				Do you drink Alcohol?			
Blood transfusion				Do you use marijuana?			
Bleeding tendency				Do you smoke?			
Epilepsy/ Seizure				Opioid Use			
Shortness of breath or chest pain on exertion				History of drug or alcohol abuse			

Are there any other conditions not listed or conditions Dr. Smythe should know about? _____

Women

Are you pregnant or trying to become pregnant? Yes No

Do you have problems associated with your menstrual period? Yes No

Are you nursing? Yes No

AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Date _____ Patient's Signature **X** _____

Doctor's Signature _____

HIPAA

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I hereby acknowledge that a copy of the Privacy Practices has been available to me for review. I have been given the opportunity to ask any question I may have regarding this notice. ****No cell phone use allowed in operatories or recovery areas. No cell calls, photos and/or videotaping/recording. This is due to the HIPAA confidentiality regulations. Thank you for your cooperation and respect for our patients and employees' privacy.***

If you are 18 and older, Please add any family that we have permission to speak to about your treatment, appointments, financials, etc.

EMERGENCY CONTACT: _____ PHONE#: _____

OK to Speak to: (Please Print Name)

OK to Speak to: (Please Print Name)

Initials

FINANCIAL AGREEMENT

Thank you for choosing St. John Oral Surgery and Dental Implants. We are committed to providing you with the highest quality care. Everyone benefits when office and financial policy arrangements are understood. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Agreement that we require you to read and sign prior to any treatment.

Payment: Payment for services is due at the time services are rendered unless prior arrangements have been made with the office. To help make dental treatment affordable to all our patients, we accept credit cards, pre-arranged in house payment plans and Care Credit®. Checks that are returned to our office from your financial institution are subject to a \$50.00 returned check fee. This fee covers the processing fees that are charged to our office. Some appointments may require a deposit to be paid before surgery can be booked. Surgeries cancelled without a 24 hour notice given will be subject to a \$500 forfeit of their deposit.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made.

Insurance: As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, necessary dental services may not be covered even though you may need those services. We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately, with the information provided to us by you and your insurance company we are happy to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed, and the claim is submitted. Your insurance plan coverage is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance estimates and deductibles must be paid at the time of service. Your complete insurance information must be presented at the time services are rendered. Insurance claims cannot be backdated. We would be happy to discuss our charges and how they relate to your situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I/We hereby authorize the assignment of any insurance benefits to the physician; and agree to be liable for the payment of all medical services performed and not paid by insurance or other benefits. I/we also agree to pay interest thereon at 1-1/2% per month (18% per annum), on any balances left due and owing. I/We also agree to pay all collection costs and reasonable attorney fees in the event this account or any future account of mine is turned over to our attorneys for collection, all without relief from valuation and appraisal laws should I/we fail to pay any amounts not paid by insurance or other benefits.

Appointments: Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment, so we ask that you kindly give us a minimum of 2 business days' notice. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If you are more than 10 minutes late for your service, we may have to reschedule your appointment. **All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.**

Thank you for understanding our Financial Agreement. Please let us know if you have any questions or concerns. **I have read the St. John Oral Surgery and Dental Implants Financial Agreement. I understand and agree to this Financial Agreement.**

Signature of Patient or Responsible Party: X _____ Date: _____

Date of Birth & Social Security # of Responsible Party: X _____