Welcome to our Practice

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
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?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 64–67)*

		Yes	No
64.	Is there a possibility of pregnancy?	❑	❑
65.	Expected delivery date? _____		
66.	Are you nursing?	❑	❑
67.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

IS THERE A FAMILY HISTORY OF:

	Yes	No		Yes	No
68. Cancer?	❑	❑	70. Heart disease?	❑	❑
69. Diabetes?	❑	❑	71. Anesthesia problems?	❑	❑

ARE YOU NOW TAKING:	YES	NO	NOTES
72. Any kind of medication, drug, pills?			
73. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
74. Have you ever taken diet pills?			
75. Any natural product, herbal supplement or homeopathic remedy?			
76. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV–Zometa, or Aredia in the past 12 years?			
77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			

78. Please list any medications you are currently taking:

Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
79. Local anesthetic (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics?			
82. Sulfa drugs?			
83. Sodium pentothal / Valium / other tranquilizers?			
84. Aspirin?			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Other medications?			
88. Latex?			
89. Soy?			
90. Eggs / yolk?			
91. Sulfites?			
92. Do you have any known allergies?			
93. Please list any allergies other than drug allergies:			

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

I certify that I have read and I understand the questions 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 doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* **X** _____ **Date** **X** _____ **Reviewed by** **X** _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* **X** _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)* **X** _____ **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* **X** _____ **Witness** **X** _____ **Doctor** **X** _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

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

Medical Information Release Form

(HIPAA RELASE FORM)

Name:_____ DOB: _____

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse:_____

[ ] Child(ren):_____

[ ] Other:_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please Call: { } my home { }my work { } my cell

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time) _____

PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: _____
Last First MI Maiden or Other Name

Date of birth: _____/_____/_____ Phone Number: _____

Address: _____City: _____State: _____Zip:_____

I grant Dr._____ and his/her practice permission to take and use photographs and digital images of me for the purpose of:

- ❑ **Teaching (i.e. Educational materials)**
- ❑ **Marketing (i.e. Web site, brochures, etc.)**
- ❑ **Other: _____**

This request and authorization applies to photography or digital images taken on:

_____
Date(s) of image capture

I understand that once my photograph(s) or digital image(s) have been released, Dr. _____ and his/her practice may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

If this authorization has not been canceled, it will expire _____ days after the date signed.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative

FINANCIAL POLICY

- The most common misconception concerning your dental and medical insurance policies is that they will cover the total cost of all consultations and surgical fees charged. That is most certainly not the case for almost all insurance policies. Insurance is designed to offset your cost, but usually will not eliminate it entirely. Your estimated out-of-pocket payment is due in full for each visit at our office at the time of service.

- This office will accept the following forms of payment for services rendered: Visa, MasterCard, Discover, American Express, Cashier's Check, and cash. We accept Care Credit (with the exception of the 12 month no interest), Lending Club and United Medical Credit for our 3rd party financing options. Additional fees may be added based on the plan selected with the 3rd party financing vendor. Although we do accept payment from 3rd party financing vendors, it is still the patient's responsibility to make sure the balance at this office are paid prior to surgery.

- Overpayment will be processed and refunded to the appropriate party according to generally accepted procedures. Refunds due to the patient/guarantor will not be processed and remitted until all active and past due, including bad dept accounts have been paid. This process typically takes 30 days.

- Insurance will be filed as a courtesy to the patient. However, coverage does not relieve the patient of financial responsibility, nor suspend payments until the insurance has been paid. This office will file on primary insurance only. It is the patient's responsibility to file on any secondary coverage. We will be happy to provide you with any information necessary to file.

- Upon receipt and verification of insurance benefits, we will attempt to estimate the patient's portion of the consultation and procedure fees due. However, this is only an estimate and neither the insurance company nor this office will guarantee this exact figure. The patient will be responsible for any coinsurance amounts prior to surgery.

- All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties unless provided in an arrangement such as a managed care contract. Any discounts/write-offs will be applied upon receipts of payments and EOB's.

- In cases of minor children with divorced parents, the parent bringing the child will be deemed the responsible party for payment. We will not be bound by a family court legal document.

- This office will send the patient or responsible party a statement showing the balance of the account after all monies have been received from the insurance company. If no insurance payment is received within sixty (60) days of service, the patient is fully responsible for payment of account. The responsible party must pay unpaid amount not covered by your insurance no later than 30 days following insurance payment.

- If payment has not been made to an account ninety (90) days after service is rendered and contact or appropriate arrangements have not been made; the account will be referred to the necessary legal authorities. This also applies for patients with insurance. After the 3rd billing cycle the account will accrue a $50.00 billing fee/late fee.

- Should you schedule a surgery appointment and not provide a 24 hour notice for cancellations, you will be charged a **$50.00 cancellation fee**. We value your time so please value ours.

- For procedures other than traditional oral surgery, in order to schedule a procedure and to secure your desired date, we must obtain a $500.00 non-refundable deposit. The remaining balance of the fees will be due upon your preoperative visit or two weeks prior to your procedure. The deposit will be applied to your procedure, however if the procedure is canceled for any reason, this balance is also non-refundable except in the case of documented emergency or medical disability. If your scheduled date is changed within (3) weeks of your procedures, an additional $250.00 deposit is required.

I have read and agree to the above policies. I understand that it is my responsibility to pay any fees to this office. This signature on file is also my authorization for the release of information necessary to process any insurance claims. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Patient/Legal Guardian Signature:_____**Date:**_____

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