I. Patient Registration

Legal Name _____ (First) _____ (Last) _____ (MI) Birth Date _____ MM/DD/YY

Preferred Name _____ Preferred Pronouns _____ Gender _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Email Address _____

Employer _____

II. Party Responsible for Payment (required)

Name _____ (First) _____ (Last) Relationship _____ Phone # _____ DOB _____

Address _____ City _____ State _____ ZIP _____

III. Medical Insurance Information

Primary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____ (First) _____ (Last)

PH Address _____

PH City/State/Zip _____

PH Employer _____

PH Relationship _____

PH Birth Date _____ PH Phone _____

ID# _____ Group # _____

SS# _____ **(required only if used as ID#)**

Secondary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____ (First) _____ (Last)

PH Address _____

PH City/State/Zip _____

PH Employer _____

PH Relationship _____

PH Birth Date _____ PH Phone _____

ID# _____ Group # _____

SS# _____ **(required only if used as ID#)**

IV. Dental Insurance Information

Primary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____ (First) _____ (Last)

PH Address _____

PH City/State/Zip _____

PH Employer _____

PH Relationship _____

PH Birth Date _____ PH Phone _____

ID# _____ Group # _____

SS# _____ **(required only if used as ID#)**

Secondary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____ (First) _____ (Last)

PH Address _____

PH City/State/Zip _____

PH Employer _____

PH Relationship _____

PH Birth Date _____ PH Phone _____

ID# _____ Group # _____

SS# _____ **(required only if used as ID#)**

V. Name of Person to Contact If Needed (required)

Name _____ Relationship _____ Phone # _____

Dentist Who Referred You _____ (First) _____ (Last)

I hereby authorize the Center for Oral and Maxillofacial Surgery, S.C. to disclose to the insurance companies named above all information contained in my health care records for the purpose of securing payment of any benefits that may be payable by said insurance companies for services rendered to me by the Center for Oral and Maxillofacial Surgery, S.C. The foregoing consent to the disclosure of my health care records shall remain in effect until such time as I deliver a written notice to the Center for Oral and Maxillofacial Surgery, S.C. stating that I have revoked my consent to the disclosure of my health care records to the insurance companies named above. If I have insurance coverage I understand that I am responsible for all charges on my account to be paid in full within 60 days following the date of service. Accounts more than 60 days past due will accrue a 1% monthly late payment charge. Accounts more than 90 days past due will be reviewed for collections unless arrangements, prior to surgery, have been made with the office administrator.

Signature of Responsible Party _____ Date _____

MEDICAL HISTORY – CONFIDENTIAL

Patient _____

Age _____ Height _____ Weight _____

Please Answer Each Question

1. What brings you to our office? _____
2. Have you been a patient in a hospital in the past 5 years? ☐ Yes ☐ No
3. For what reason? _____
4. Have you ever been under the care of a physician during the past 5 years? ☐ Yes ☐ No
5. For what reason? _____
6. Have you ever taken any kind of medication to increase bone density or prevent bone destruction for osteoporosis or cancer? ☐ Yes ☐ No

6a. List all medications (including herbal remedies) taken during the past year. _____

_____

_____

7. List all allergies to medications, foods, latex, etc. _____

_____

7a. What kind of reaction did you have to the medication(s)? _____

_____

7b. Preferred Pharmacy _____ Phone # _____

8. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
9. Select any of the following which you have had:

☐ heart trouble	☐ asthma	☐ epilepsy	☐ artificial joints or grafts e.g., hip or valve replacement
☐ congenital heart lesions	☐ cough	☐ motion sickness	☐ ADHD
☐ heart murmur	☐ diabetes	☐ sleep apnea	☐ Autism
☐ high blood pressure	☐ tuberculosis	☐ mood disorder	Major surgery, Date/Year:
☐ anemia	☐ jaundice	☐ thyroid	_____
☐ rheumatic fever	☐ arthritis	☐ cholesterol	_____
☐ hepatitis	☐ stroke	☐ HIV/Aids	_____
			_____
			_____

10. Have you ever had any other serious illness? ☐ Yes ☐ No
11. Have you been diagnosed with any immune disorder? (Radiation treatment, Chemotherapy, Splenectomy, Steroid use) ☐ Yes ☐ No
12. Have you ever had any problems with your temporomandibular joints (jaw joints); e.g., noises, pain, or limited opening? ☐ Yes ☐ No
13. Do you smoke? ☐ Yes ☐ No
14. Are you pregnant? ☐ Yes ☐ No
15. Have you or anyone in your family had any problems with general anesthesia? ☐ Yes ☐ No
16. Has a member of your family been seen in our office before? ☐ Yes, Relative _____ ☐ No
17. Are you wearing contact lenses? ☐ Yes ☐ No

ACKNOWLEDGMENT OF ANESTHESIA AND MEDICATION USE IN YOUR CARE

I acknowledge that certain medications that may be prescribed to me by my doctor at The Center for Oral & Maxillofacial Surgery, s.c. may alter my state of mental awareness and decision making. Depending on the type of anesthetic given, I understand the importance of adhering to the following:

- Refrain from driving a car.
- Refrain from operating machinery of any kind.
- Refrain from making important personal or business decisions.
- Refrain from drinking alcohol of any kind.
- Refrain from taking sedatives (prescribed by another doctor or over-the-counter).

PATIENT FINANCIAL POLICY

Payment is expected at the time of service for any office procedure, including consultation and x-rays. For patients covered by a Medical/Dental insurance plan, we will assist you in filing your insurance forms. Most insurance companies will respond within four to six weeks. Please note that insurance rarely pays the entire treatment balance, even if your policy states “100% coverage”. All account balances are ultimately the responsibility of the patient or guardian. Patient, parent or guardian signature is required before treatment begins.

The experienced staff is here to assist our patients. We make every effort to provide you with the finest care, and the most convenient financial options. To accomplish this, we work hand-in-hand with you to maximize your insurance reimbursement for covered procedures.

If your account has a remaining balance it may be paid by cash, check, debit card, Visa, MasterCard, Discover, American Express, or CareCredit. You will receive a statement from our office, which is payable upon receipt. Overdue accounts will be sent to an independent collection agency and/or small claims court.

Any separated or divorced parent accompanying a dependent child for treatment will be considered to be the financially responsible guarantor.

I understand the payment policy and have read it in its entirety. I hereby authorize the release for pertinent medical information necessary for my treatment. I verify that the information I have provided is accurate.

Please remember, you are fully responsible for all fees charged by this office regardless of your insurance coverage.

CANCELLATION POLICY

We understand that unforeseen circumstances may arise. If you need to cancel or reschedule your appointment, we kindly request at least 24 hours' notice. Please note that if a Friday appointment is canceled, future Friday appointments may not be available due to limited availability.

Repeated missed or late-canceled appointments limit our ability to serve other patients. After three such occurrences, we may no longer be able to schedule future appointments for you.

We appreciate your understanding and cooperation as we strive to provide the highest level of care to all patients.

REQUEST TO ACCESS AND DISCLOSE PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies of their Protected Health Information (PHI). Additionally, this act provides for an individual to designate person(s) they are associated with, such as parent, guardian, spouse, child, etc. (this is in addition to their personal physician or dentist) to have access to their PHI. This allows an individual to designate the name(s) or person(s) with whom this confidential information may be shared.

Please print the name of designated person(s) & relationship below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

CERTIFICATION STATEMENT

My signature below indicates that I have read, understand and acknowledge the Acknowledgement of Anesthesia and Medication Use, Patient Financial Policy and the Request to Access and Disclose Protected Health Information Policy. I acknowledge that a copy of the privacy policies for The Center for Oral and Maxillofacial Surgery, s.c. were given/offered to me. I certify that the above information is true to the best of my knowledge. I hereby authorize the Center for Oral Maxillofacial Surgery and Dental Implants to release any information required to process my insurance claim/s for services rendered. I understand that I am ultimately financially responsible for any required payment prior to services rendered and any balance remaining on the account after insurance has processed. I also acknowledge that cell phones are not allowed by any patient and/or parent/guardian back in the surgical and recovery areas due to patient privacy.

Signature _____ Date _____

☐ I am the patient

☐ I am the parent/guardian

☐ Other _____