ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, PA
Dr. David E. Seago • Dr. Jeffrey S. Brown

PATIENT INFORMATION

Patient's Name _____ (LAST) _____ (FIRST) _____ (MI) Nickname _____

Patient's Mailing Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Home Phone _____ Email _____

DOB _____ Sex: ❑ Male ❑ Female Social Security Number _____ Marital Status _____

Name of Parent / Spouse _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Unemployed – Your Employer _____

Student: ❑ Full Time ❑ Part Time ❑ N/A – School Name _____

Reason for visit today? _____

Have we seen you before? ❑ Yes ❑ No – If Yes, when did we see you last? _____

Please list your: Dentist _____ Orthodontist _____ Physician _____

How did you hear about us? _____

Emergency Contact Name _____ Relationship _____ Phone _____

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE

Height _____ Weight _____ Please rate your discomfort on a scale from 1-10 (10 being highest) _____

Are you currently under the care of a physician? . . . . . ❑ Yes ❑ No

If yes, reason _____

Have you had any previous surgeries / have you been hospitalized overnight? . . . . . ❑ Yes ❑ No

Are you currently taking / have you ever taken and medication for osteoporosis or other bone / cancer disease? . . . . . ❑ Yes ❑ No

If yes, medication _____

Have you, or an immediate family member, experienced anesthetic complications? . . . . . ❑ Yes ❑ No

If yes, explain _____

Do you use tobacco products? . . . . . ❑ Yes ❑ No

If yes, is the tobacco product you use: ❑ Smoke ❑ Smokeless

Do you pre-med for dental procedures? . . . . . ❑ Yes ❑ No

Do you have any developmental / psychological disabilities? . . . . . ❑ Yes ❑ No

Are you pregnant, or is there a possbility you could be pregnant? . . . . . ❑ Yes ❑ No

If yes, how many months? _____ If no, when was your last menstrual cycle? _____

CHECK ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST?

❑ Anemia
❑ Artificial Heart Valve
❑ Asthma / Emphysema
❑ Bleeding Problems
❑ Blood Borne Disease
❑ Blood Transfusion
❑ Contagious Disease
❑ Diabetes
❑ Difficulty Breathing
❑ Glaucoma
❑ Heart Trouble
❑ Hemophilia
❑ Hepatitis
❑ High / Low Blood Pressure
❑ HIV / AIDS
❑ Jaundice
❑ Joint Replacement
If yes, when _____
❑ Kidney Trouble
❑ Liver Trouble
❑ Lung Trouble
❑ Mitral Valve Prolapse
❑ Nervous Problems
❑ Osteoporosis
❑ Porphyria
❑ Problem with Tooth Extraction
❑ Radiation Therapy to Face
❑ Rheumatic Fever
❑ Seizures / Fainting
❑ Shortness of Breath
❑ Stomach Ulcers
❑ Substance Abuse
❑ Thyroid Problems
❑ TMJ Problems
❑ Tuberculosis
❑ Other _____

DRUG AND ALCOHOL USE, IF APPLICABLE

The information you provide is protected under the Health Insurance Portability and Accountability Act and will NOT be shared with anyone. It is important to note that some substances may have adverse reactions or interactions with anesthetic medication administered during a surgical procedure. The information provided below will allow our team to adequately administer the proper medications for optimum comfort and safety.

Do you drink alcohol? . . . . . ❑ Yes ❑ No

If yes: ❑ Daily ❑ Occasionally ❑ Excessively

Do you use recreational drugs? . . . . . ❑ Yes ❑ No

If yes, substance type _____

I hereby certify that I have answered the above questions correctly and accurately, and I authorize the release of medical information.

Patient's Signature (or Guarantor if patient is minor) _____ Date _____

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LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dosage	Frequency

MEDICATION ALLERGIES

❑ **NONE** _____

PHARMACY INFORMATION

Name _____ Location _____ Phone _____

I hereby certify that I have answered the above questions correctly and accurately, and I authorize the release of medical information.

Patient's Signature (or Guarantor if patient is minor) _____ Date _____

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Patient's Name _____ Guarantor's Name (if patient is a minor) _____

Guarantor's Social Security Number_____ Guarantor's Date of Birth _____

Guarantor's E-Mail _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE POLICY

It is your responsibiliy to contact your insurance company and find out if we are a participating provider with your insurance plan.

As a courtesy, we will file your insurance claim unless otherwise stated. We are contracted with multiple insurance companies to accept an assignment of benefits for our services. Even though we can file a claim to any insurance plan, we may not be on the type of plan you or your company may have selected. In order for us to file your insurance claim on your behalf, you must provide **a valid insurance card at the initial appointment and any time thereafter if your insurance carrier changes.**

Your co-pay portion is expected at the time of the exam. **Half of your estimated surgical deposit must be paid at the time of scheduling and the remaining half at the time of surgery.** We will work with your insurance carrier for 60 days from the date of the initial filing of the insurance claim. If at that time we have not received payment from your insurance carrier, we will then bill you for the balance owed on the account.

Our office accepts Cash, Check, Visa, American Express, MasterCard, Discover and are also partnered with CareCredit and GreenSky Lending.

We are happy to provide you with the necessary information (x-rays, ADA codes, etc.) for you to work with your insurance carrier on resolving your claim.

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone _____
ID Number _____
Group Number _____
Policy Holder's Name _____
Relationship to Patient _____
Policy Holder's SS# _____
Policy Holder's Employer _____
Policy Holder's Birthdate _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone _____
ID Number _____
Group Number _____
Policy Holder's Name _____
Relationship to Patient _____
Policy Holder's SS# _____
Policy Holder's Employer _____
Policy Holder's Birthdate _____

SECONDARY MEDICAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone _____
ID Number _____
Group Number _____
Policy Holder's Name _____
Relationship to Patient _____
Policy Holder's SS# _____
Policy Holder's Employer _____
Policy Holder's Birthdate _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone _____
ID Number _____
Group Number _____
Policy Holder's Name _____
Relationship to Patient _____
Policy Holder's SS# _____
Policy Holder's Employer _____
Policy Holder's Birthdate _____

AUTHORIZED SIGNATURE _____ DATE _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (PHI)

The Notice of Privacy Practices is posted in the waiting room and on our website for your review. You may also request a copy. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES FOR PHI:

(you may refuse to sign this acknowledgement)

I have read and understand Oral Surgery Associates Notice of Privacy Practices.

_____ _____ _____

Printed Name of Patient/Guardian | Signature of Patient/Guardian | Today's Date

FOR OFFICE USE ONLY:

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

☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining acknowledgement

☐ Communication barriers prohibited obtaining the acknowledgement ☐ Other (please specify) _____

Employee Signature: _____ Today's Date: _____

HIPAA PRIVACY STATEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. Below summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this authorization to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

AUTHORIZATION FOR THE RELEASE OF YOUR PROTECTED HEALTH INFORMATION:

(Choose Option 1 or Option 2. If you choose Option 2, please answer Sections 1-4 completely)

OPTION 1: _____ (initial) Oral Surgery Associates may discuss protected health information about me ONLY with me.

OPTION 2: _____ (initial) I authorize Oral Surgery Associates to use and disclose protected health information about me as described below. **(please answer Sections 1-4 completely)**:

SECTION 1: I hereby authorize the release of PHI about me to the people listed below:

1. _____, _____ 2. _____, _____

Authorized Person | Relationship to Patient | Authorized Person | Relationship to Patient

SECTION 2: I authorize the release of PHI listed in Section 1 covering the period of my health care from (select one):

☐ all past, present and future periods

☐ _____ (date) to _____ (date)

SECTION 3: I hereby authorize the release of PHI to the people listed in Section 1 as follows (select one):

☐ My complete health records

☐ My complete health record with the exception of the following:

☐ Mental Health Records ☐ Communicable Diseases ☐ Alcohol/Drug Abuse Treatment ☐ Other _____

SECTION 4 (please initial): _____ This medical information may be used by the people I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, and I understand that information used or disclosed pursuant to this authorization may be protected by federal or state law. This authorization shall be in force and effect until otherwise revoked in writing, at which time will expire.

_____ _____ _____

Printed Name of Patient/Guardian | Signature of Patient/Guardian | Today's Date

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CANCELLATION POLICY/NO SHOW POLICY
FOR CONSULT APPOINTMENTS AND SURGERY

1. Cancellation/No Show Policy for Consult Appointment

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
   IF AN APPOINTMENT IS NOT CANCELLED AT LEAST 48 HOURS IN ADVANCE YOU WILL BE CHARGED A FIFTY DOLLAR ($50) FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

2. Cancellation/No Show Policy for Surgery

   Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.
   IF SURGERY IS NOT CANCELLED AT LEAST 48 HOURS IN ADVANCE OF THE DATE OF THE ACTUAL SURGERY, YOU WILL BE CHARGED 20% OF THE TOTAL SURGICAL FEE; THIS IS NOT COVERED BY YOUR INSURANCE COMPANY.

_____ _____

Patient Name (Print) Signature Patient/Guardian

_____ _____

Date Patient Account #
(Office Use Only)