Southlake
Oral & Maxillofacial
Surgery

PATIENT INFORMATION

Name _____ **Nickname** _____
(Last, First, Middle Initial)

Address _____ **City** _____ **Zip** _____

Date of Birth _____ **Social Security #** _____ **E-Mail**_____

Home Phone # _____ **Patients Cell Phone #** _____

Parent or Guardian Cell Phone #'s _____

Patient Employer _____ **Patient Work Phone #** _____

Emergency Contact _____ **Phone #** _____ **Relationship** _____

Marital Status: ☐Single ☐Married ☐Divorced **Physician** _____

Full-Time Student: ☐YES ☐NO **General Dentist** _____

School Attending: _____

Who Referred You to Us? _____ **Orthodontist** _____

PHARMACY NAME & NUMBER_____ **Payment Method:** ☐Cash ☐Check ☐Credit Card

PRIMARY INSURANCE HOLDER / RESPONSIBLE FOR ACCOUNT

(Insurance Companies are NOT considered responsible parties)

NAME OF DENTAL INSURANCE CARRIER (Company): _____

NAME OF MEDICAL INSURANCE CARRIER (Company): _____

Relationship ☐SELF ☐SPOUSE ☐PARENT ☐OTHER: _____
(If "self" no need to fill out duplicate information below)

Subscribers Name _____ **Member ID#:**_____

Address _____ **City** _____ **Zip** _____

Date of Birth _____ **Social Security #** _____ E-Mail_____

Home Phone # _____ **Cell Phone #** _____

Employer _____ **Work Phone #** _____

I certify that the information given above is true and correct to the best of my knowledge. (Copies of insurance cards have been taken.)
I have received a copy of this practice's Notice of Privacy Practices and have been given the opportunity to discuss it.
I authorize release of any and all necessary information to my insurance provider for this practice to generate & receive payment directly. I understand that I am financially responsible for the balance on my account regardless of insurance status.

_____ _____
Date **Signature of Responsible Party / Patient**

Check all conditions that apply, Yes (Y) or No (N) **HEALTH HISTORY** **All responses are kept confidential**

1. Date of last physical exam _____
2. Are you in good health? ☐Y ☐N
3. Any health changes over the past year? ☐Y ☐N
4. Serious illnesses, operations, or hospitalizations. (Please list)

_____ _____
_____ _____
_____ _____

5. Do you have history of any of these conditions or diseases (Dz)?

- Cardiovascular Dz ☐Y ☐N
  ☐ *Heart Attack* ☐ *Stroke* ☐ *High Blood Pressure*
  ☐ *Heart Surgery* ☐ *Angina* ☐ *Coronary Artery Dz*
  ☐ *Heart Failure* ☐ *Arrhythmia* ☐ *Rheumatic Heart Dz*
  ☐ *Heart Murmur* ☐ *Chest Pain* ☐ *Damaged Valve*
- Lung Dz ☐Y ☐N
  ☐ *Emphysema* ☐ *Asthma* ☐ *Shortness of Breath*
  ☐ *Pneumonia* ☐ *Bronchitis* ☐ *Chronic Cough*
  ☐ *Tuberculosis*
- Liver Dz ☐Y ☐N
  ☐ Jaundice ☐ *Hepatitis* ☐ *Cirrhosis*
- Blood Dz ☐Y ☐N
  ☐ *Hemophilia* ☐ *Anemia* ☐ *Prolonged Bleeding*
  ☐ *Transfusion* ☐ *Easy Bruising*
- Gastrointestinal Dz ☐Y ☐N
  ☐ *Reflux* ☐ *Ulcers* ☐ *Colitis*
- Neurological Dz ☐Y ☐N
  ☐ *Epilepsy* ☐ *Seizures* ☐ *Psychiatric Therapy*
- Muscle / Bone Dz ☐Y ☐N
  ☐ *Arthritis* ☐ *DJD* ☐ *Myasthenia Gravis*
- Immunodeficiency ☐Y ☐N
  ☐ *Chemotherapy* ☐ *HIV AIDS* ☐ *Organ Transplant*
- Cancer ☐Y ☐N
- Kidney Dz ☐Y ☐N
- Thyroid Dz ☐Y ☐N
- Diabetes ☐Y ☐N
- Glaucoma ☐Y ☐N
- Sinus Problems ☐Y ☐N
- Snoring, Sleep Apnea ☐Y ☐N
- Recurrent Infections ☐Y ☐N
- Recurrent Mouth Sores ☐Y ☐N
- Anxiety Disorder, Fainting ☐Y ☐N
- Jaw Joint Problems ☐Y ☐N
  ☐ *Pain* ☐ *Pop* ☐ *Grind* ☐ *Clench* ☐ *Limited Opening*

6. Do you have difficulty:
   - Doing yard work (rake, mow)? ☐Y ☐N
   - Climbing 1 flight of stairs? ☐Y ☐N
   - Running a short distance? ☐Y ☐N

7. Do you smoke? Packs per day _____ ☐Y ☐N
8. Have you (or relatives) had anesthesia problems? ☐Y ☐N

9. Are you taking any of the following?
   - Cancer meds, chemotherapy ☐Y ☐N
   - Immune system suppression meds ☐Y ☐N
   - Steroids ☐Y ☐N
   - Diabetes meds (insulin, oral meds) ☐Y ☐N
   - Anticoagulants (blood thinners) ☐Y ☐N
   - Aspirin, Motrin, Aleve, Advil, Ibuprofen ☐Y ☐N
   - High blood pressure meds ☐Y ☐N
   - Heart medication (digitalis, inderal, nitroglycerin) ☐Y ☐N
   - Tranquilizers ☐Y ☐N
   - Recreational drugs (cocaine, meth, etc.) ☐Y ☐N

10. Current Medications (List Below and Star (*) if taken today)

_____ _____
_____ _____
_____ _____
_____ _____

11. Have you ever had any of these treatments?
    - Head or Neck Radiation therapy ☐Y ☐N
    - Steroid therapy within the last 2 years ☐Y ☐N
    - Professional care for drug abuse, alcoholism ☐Y ☐N
    - Medical Implant ☐Y ☐N
      ☐ *Heart Valve* ☐ *Pacemaker* ☐ *Pump* ☐ *Joint*
      ☐ *Artery Stent* ☐ *Defibrillator* ☐ *Shunt* ☐ *Breast*
    - Osteoporosis or Bone Cancer medication ☐Y ☐N
      ☐ *Fosamax* ☐ *Actonel* ☐ *Boniva* ☐ *Zometa* ☐ *Aredia*

12. Allergies or Drug Reactions
    - Local Anesthetics (Novocaine, Epinephrine) ☐Y ☐N
    - General Anesthetics (Sedatives, Barbiturates) ☐Y ☐N
    - Penicillin, Amoxicillin ☐Y ☐N
    - Tetracycline ☐Y ☐N
    - Other Antibiotics ☐Y ☐N
    - Ibuprofen, Aspirin ☐Y ☐N
    - Hydrocodone or other pain medicine ☐Y ☐N
    - Eggs ☐Y ☐N
    - Latex or Rubber Products ☐Y ☐N
    - Other allergies or reactions (Please List Below) ☐Y ☐N

_____
_____

WOMEN ONLY

13. Are you Pregnant? **Any chance you might be?** ☐Y ☐N
14. Are you nursing? ☐Y ☐N

* Surgery, anesthetics, and other medications may significantly harm a developing baby. Please advise us if there is any chance of pregnancy.

* Some medications interfere with oral contraceptive effectiveness and require the use of mechanical forms of birth control for one complete **CYCLE FOLLOWING COMPLETION OF THE MEDICATION COURSE.**

I certify that this Health History is true and correct to the best of my knowledge and I have had an opportunity to discuss it with my doctor.

_____ _____ _____ _____
DATE **PATIENT NAME** **PATIENT / PARENT SIGNATURE** Doctor Initials

FINANCIAL AGREEMENT

Assignment of Benefits:
I hereby assign benefits to be paid, on my behalf, to the physician who renders service. I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third party payer and certify that the information given with regard to insurance coverage is correct.

Release of Information:
I authorize the physician rendering service to release all or part of my medical records when required for the submission of any insurance claims for payment of services rendered. The physician, his agents and his employees who render service are hereby released from any and all liability of any nature that may arise from the release of such information.

Disclosure Agreement:
I have been informed that the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the above referenced facility.

Insurance:
If we are a provider for your insurance, the planned procedures may be covered under your policy for a reduced fee. **IF COVERAGE IS DENIED, THE FEES LISTED ON THE TREATMENT PLAN ARE YOUR RESPONSIBILITY**. A case predetermination will be filed with your insurance carrier to help determine the benefits of your individual policy and obtain an **ESTIMATE.** We will collect your portion of the charges at the time of service. We do not file claims to secondary insurance carriers. Please understand that your insurance policy is a contract between you and your carrier, not our office. If your insurance carrier has not issued payment within 45 days of service, any unpaid professional fees are due and payable in full from you.

Dental Insurance:
As a courtesy to our patients with dental insurance, we bill insurance carriers directly. HMO and DMO insurance plans require a specialist referral and pre-authorization prior to service. Co-pays, deductibles, and fees not covered by your insurance carrier are due at the time of service. Secondary insurance policies are not accepted and will not be filed. We will provide you with any information to file a secondary claim on your own.

Medical Insurance:
Since we are not contracted with your medical insurance company, our office is not obligated to file with your medical insurance carrier. Since medical predeterminations are not guarantees of payment, **THE FEES LISTED ON THE TREATMENT PLAN WILL BE COLLECTED PRIOR TO YOUR SURGICAL PROCEDURE**. Any over payments will be refunded if your insurance company remits payment for your claim. If your carrier requests supplementary information to predetermine your case (radiographs, models, dictations) a $50 fee will be your responsibility.

Biopsies:
If the specimen is sent for pathologic examination, the pathologist will bill you directly for his/her services.

Payment Options:
We accept cash, check, MasterCard, Discover and Visa. Payment plans are available through Care Credit.

Financial Policy
- A $50 fee will be assessed for cancelations with less than 24 hr notification.
- A $100 fee will be assessed for unattended scheduled surgery appointments.
- A monthly fee of $5.00 will be assessed for account balances past 60 days until balance is paid in full.
- A $25 fee is due for each check payment returned by your bank.
- Any collection fees, court costs, or reasonable attorney fees required to collect unpaid accounts are your responsibility.
- A $25.00 fee will be assessed for any FMLA or Short term disability requests.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts the terms as specified above.

Responsible Party:	**Witness:**
_____	_____
Signature	Signature
_____	_____
Date/Time	Date/Time
_____	_____
Printed Name	Printed Name

Submit Forms

Print Forms