Oral & Maxillofacial Surgery & Implantology
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OMS
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Date _____

PATIENT INFORMATION

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

Sex: ❑ M ❑ F Birth Date _____ Age _____ How would you like to be addressed_____

Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

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

General Dentist _____ _____ Pharmacy_____ Tel (____)_____
FIRST NAME LAST NAME

Student: ❑ Full Time ❑ Part Time ❑ Not - School Name_____ Expected Graduation Date_____

Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Other

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

Employer_____ Position_____ Bus. Tel.(____) _____

If patient is under 18:

*Mother's Name*_____ _____ *Tel (____)* _____
FIRST NAME LAST NAME

Father's Name _____ _____ *Tel (____)* _____
FIRST NAME LAST NAME

Person bringing patient to appointment - They are responsible for any co-pay/payments due at this appointment.

Name_____ _____ Relation _____ S.S.# _____ Birth Date _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____ Tel. (_____) _____

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

(If self, skip to next section)

Name_____ _____ S.S.#_____ Birth Date _____ Age_____
FIRST NAME LAST NAME

Tel.(____) _____ Business Tel. (____) _____

Street_____ City_____ State _____ Zip_____

ALL THE INFORMATION BELOW PERTAINS TO THE PERSON WHO HOLDS THE INSURANCE

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name_____

Address _____

_____ _____ _____ Tel.(____) _____
CITY STATE ZIP

Group #_____ **Group Name**_____

I.D. # _____

Policy Holder _____ _____
FIRST NAME LAST NAME

Relation _____ Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

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

Employer _____ Bus. Tel.(____) _____

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name_____

Address _____

_____ _____ _____ Tel.(____) _____
CITY STATE ZIP

Group #_____ **Group Name**_____

I.D. # _____

Policy Holder _____ _____
FIRST NAME LAST NAME

Relation _____ Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

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

Employer _____ Bus. Tel.(____) _____

SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name_____

Address _____

_____ _____ _____ Tel.(____) _____
CITY STATE ZIP

Group #_____ **Group Name**_____

I.D. # _____

Policy Holder _____ _____
FIRST NAME LAST NAME

Relation _____ Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

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

Employer _____ Bus. Tel.(____) _____

SECONDARY MEDICAL INSURANCE COMPANY

Ins. Co. Name_____

Address _____

_____ _____ _____ Tel.(____) _____
CITY STATE ZIP

Group #_____ **Group Name**_____

I.D. # _____

Policy Holder _____ _____
FIRST NAME LAST NAME

Relation _____ Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ _____ _____
CITY STATE ZIP

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

Employer _____ Bus. Tel.(____) _____

SOCIAL SECURITY NUMBERS ARE USED TO VERIFY INSURANCE COVERAGE. IF NOT PROVIDED, PAYMENT WILL BE EXPECTED IN FULL.

Patient Name _____

HEALTH HISTORY

To our patients: Correct answers to the following questions are extremely important to enable your doctor to treat you on a more individual basis, and to provide care appropriate to your needs. Be assured that strict confidentiality of your health and treatment record will be maintained at all times, and treatment will not be denied to you based on your honest answers. If you are uncertain or uncomfortable answering any of these questions, you may discuss your concerns privately with your doctor.

Reason for today's office visit _____

Whom may we thank for referring you? _____

	Yes	No
1. Are you in good health? ..... Height _____ Weight _____	❑	❑
2. Have there been any changes in your general health in the past year?	❑	❑
3. Are you under the care of a physician or specialist? ..... Date of last visit _____	❑	❑
Name of physician/specialist _____ (FIRST NAME) _____ (LAST NAME) Phone (____) _____		
For what are you being treated? _____		
4. Have you had any illnesses, operations or been hospitalized?	❑	❑
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 any artificial joint(s)/implant(s)? *If so, describe where* _____	❑	❑
7. Have you had a heart valve replacement, vascular graft, or stent?	❑	❑
8. Do you pre-medicate with antibiotics for dental appointments?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
9	Rheumatic fever?			
10	Damaged heart valves / mitral valve prolapse?			
11	Heart murmur?			
12	Congenital heart disease?			
13	High blood pressure?			
14	Low blood pressure?			
15	Chest pain / angina?			
16	Heart attack(s)?			
17	Irregular heart beat?			
18	Cardiac pacemaker?			
19	Shortness of breath?			
20	Pneumonia / bronchitis / chronic cough / emphysema?			
21	Cough up bloody sputum or blood?			
22	Asthma?			
23	Hay fever / sinus problems / nose bleeds?			
24	Sleep apnea?			
25	Tuberculosis or other lung trouble?			
26	Do you smoke?			
27	Do you use chewing tobacco?			
28	Blood transfusion?			
29	Blood disorder such as anemia?			
30	Bruise easily or hemophilia?			
31	Any recent skin changes / disease?			
32	Bleeding tendency / abnormal bleeding during previous extractions?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
33	Hepatitis, jaundice, or liver disease?			
34	Infectious mononucleosis?			
35	Fainting spells?			
36	Headaches / migraines?			
37	Convulsions / epilepsy?			
38	Stroke?			
39	Thyroid trouble / goiter?			
40	Diabetes?			
41	Low blood sugar?			
42	Kidney trouble?			
43	Are you on dialysis?			
44	Osteoporosis / Osteopenia?			
45	Arthritis / rheumatism?			
46	HIV / AIDS?			
47	Herpes?			
48	Are you immunosuppressed? Possibly from transplant surgery, etc.			
49	Persistent fever?			
50	Delay in healing?			
51	Any tumor(s) or growth(s)?			
52	Cancer / radiation therapy / chemotherapy?			
53	Are you on a diet, or have had any marked weight change?			
54	Chronic fatigue / night sweats?			
55	Do you drink more than 2 alcoholic beverages per day?			
56	Psychiatric treatment (Depression, Anxiety, Bipolar, etc.)?			
57	Eye disease / glaucoma?			

Please Note: All numbering is not sequential.

MEDICATION – Are you now taking. . .		*Yes*	*No*	*NOTES*
58	Any kind of medication, drug, pills?			
59	Blood thinners (Coumadin, Plavix, Xarelto, Eliquis, Fish Oil, Aspirin, Vitamin E, Ginko Biloba, etc.)?			
60	Have you ever taken diet pills?			
61	Any natural product, herbal supplement or homeopathic remedy?			
62	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva, Xgeva, Prolia)?			
63	List all medications you are currently taking, including daily supplements:			

ALLERGIES – Are you allergic to, or had a reaction to. . .		*Yes*	*No*	*NOTES*
64	Local anesthetic (numbing med.)?			
65	Penicillin, amoxicillin, or augmentin?			
66	Other antibiotics?			
67	Sulfa Drugs (antibiotics)?			
68	Versed, Valium, or other tranquilizers?			
69	Aspirin?			
70	Codeine, Fentanyl, or other narcotics?			
71	Other medications?			
72	Latex?			
73	Soy?			
74	Eggs / Yolk?			
75	Sulfites (preservative)?			
76	Please list any allergies other than drug allergies:			

Are you nervous about possibly needing oral surgery?
❑ No ❑ Slightly ❑ Moderately ❑ Extremely

Do you have, or have you ever been diagnosed with or treated for, TMJ disorder?
❑ Yes ❑ No

Clicking / Popping	❑ Yes	❑ No
Difficulty Opening / Closing	❑ Yes	❑ No
Clenching / Grinding	❑ Yes	❑ No
Lock Jaw	❑ Yes	❑ No

Does your jaw feel sore after dental appointments? ❑ Yes ❑ No

Do you have any neck or back pain / disorders that would make dental chairs a difficulty? ❑ Yes ❑ No

Is there any other condition concerning your health of which the doctor should be made aware?
❑ Yes (if so, describe) _____
❑ No

DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING?
❑ **Yes** ❑ **No**

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship _____

Home Tel.(_____) _____

Bus. Tel.(_____) _____

Cell Tel.(_____) _____

THIS SECTION (77 – 80) IS FOR WOMEN ONLY

77 Is there a possibility of pregnancy? ❑ Yes ❑ No

78 Expected delivery date _____ / _____ / _____

79 Are you nursing? ❑ Yes ❑ No

80 Are you taking birth control pills? ❑ Yes ❑ No

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

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 surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Fees and Payments

We make every effort to keep down the cost of your oral surgical 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, please complete the identifying information on this form.

Payment by check is always welcomed, however, if your check is returned for non-sufficent funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. Returned checks are subject to a $25 fee and balances over 90 days may be subjected to interest charges of 1.5% per month or 18% per year and any additional collection fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its term and conditions. Charges may also be made for broken appointments and appointments cancelled without 24-hour advance notice.

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 for any unpaid balance.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Greene & Torio, OMFS, LLP, of the benefits otherwise payable to me.

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.

Witness: X _____

X _____ X _____

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

Doctor: X _____

Financial Policy / Insurance Information

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are available to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

We deliver the finest care at the most reasonable cost to our patients; and we ask that payment be made at the time service is rendered unless other arrangements have been made in advance. For your convenience, we accept checks, cash, debit cards, Visa, MasterCard, Discover, and Care Credit. Care Credit is a healthcare credit program offered to patients by an independent company. This allows payment over time, and takes only a few minutes to apply and determine eligibility. Our financial coordinators can help you apply or you can visit www.carecredit.com for more information. If you have questions regarding your account, please contact us at (603) 883-4008. Many times, a simple telephone call will clarify any questions or misunderstandings.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Not all services are a covered benefit in all insurance contracts. Insurance companies differ in their policies regarding coverage of procedures or services that a doctor may provide. They may arbitrarily select certain services they will not cover. Depending on your specific policy, it may require you, as the subscriber, to pay nothing, a deductible, or a portion of the fee; or it may require you to pay for the entire procedure or service.

2. We choose not to participate in managed care/PPO/HMO contracts with medical insurances because we feel it will not allow us to provide the level of care and service that our colleagues and patients have come to expect of us and that we demand of ourselves. However, some of these plans with "out of network" benefits will reimburse you for a portion of your total cost, in addition to any dental insurance coverage you may have.

3. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. ***We must emphasize that our relationship is with you, the patient, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, you are fully responsible for all fees charged by this office regardless of your insurance coverage.***

We are happy to offer pre-treatment estimates for major surgeries. Please be aware that this is an estimate only and charges may actually be higher or lower depending on the nature of your procedure. Insurance coverage estimates may also vary, being higher or lower, depending on deductibles and pending claims that are processed after we review coverage. You should be aware that any other treatment you may have already received will reduce your remaining benefits allowed by your dental insurance contract.

Most insurance companies will process claims within four to six weeks. We will send you a monthly statement. Please call our office if your statement does not reflect your insurance payment within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated. We realize that temporary financial problems may affect the 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.

We appreciate the opportunity to care for you. If you have any questions about the above information or any uncertainty regarding insurance coverage, *please* don't hesitate to ask us. We are here to help you.

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