Stateline Oral & Maxillofacial Surgery, PC

PATIENT INFORMATION

Name____Birth Date ____/____/_____Age_____
Home Address______________________________________ Apt. Number_________________
City____________________________ State_____________________ Zip Code____________
Home Phone____________________Business Phone________________Cell______________________
Sex: ❒M ❒F Marital Status: ❒Single ❒Married ❒Divorced ❒Widow Social Security #_____-____-____
Patient Employed by __________________________________Occupation_________________________
Business Address______________________________________Email_____________________________

Emergency contact name_____________________________Phone Number_______________________

Whom may we thank for referring you here today?____
Who is your Dentist?__________________________ Orthodontist?_______________________________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Company _______________________________Phone Number__________________
Insurance Address____
Primary Subscriber____Birth Date______/______/______
Subscriber ID # _____________________________Policy Group # ___________________
Relationship to Patient____Social Security #______-______-______
Primary Subscriber Employer____________________________________Business Phone__________________

Secondary Dental Insurance Company ______________________________Phone Number__________________
Insurance Address____
Secondary Subscriber____Birth Date______/______/______
Subscriber ID # _____________________________Policy Group # ___________________
Relationship to Patient____Social Security #______-______-______
Secondary Subscriber Employer__________________________________Business Phone__________________

MEDICAL INSURANCE INFORMATION

Medical Insurance Company _____________________________________Phone Number___________________
Insurance Address____
Subscriber____Birth Date______/______/______
Subscriber ID # ____________________________Policy Group # ___________________
Relationship to Patient____Social Security #______-______-______
Subscriber Employer____Business Phone ____________________

I authorize payment of my dental/medical benefits directly to Stateline Oral & Maxillofacial Surgery, PC for all services, also the use of this signature on all insurance submissions. I authorize Stateline Oral & Maxillofacial Surgery, PC to release all information necessary to secure the payment of benefits.

Primary Dental Subscriber Signature:____Date:________________

Secondary Dental Subscriber Signature: _______________________________________Date:________________

Medical Subscriber Signature:____Date:________________

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MEDICAL HISTORY FORM

Name: ______________________________ Date: ______________________________

Date of Birth: ___________________________ Sex: M / F Height: __________ Weight: _____________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
   If so, please explain:
3. Are you now under the care of a physician? .... Yes No
   If yes, for what condition?

   The name and address of my physician is:

   Please list the date of your last physical examination: ____________
4. Have you had any serious illness, significant operation or hospitalization within the past 5 years? .... Yes No
5. Do you take blood thinning medications? .... Yes No
6. Are you taking any medications? .... Yes No
   (this would include all non-prescription, homeopathic or "natural" remedies including diet pills)
   If Yes, Please list ALL medications:

7. **Are you allergic to any medication?** .... Yes No
   If so, please identify your medication allergies:
   a. Local anesthetics .... Yes No
   b. Penicillin or antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Latex or rubber products .... Yes No
   i. Other, please list:

8. Do you have or have you had any of the following diseases or problems?
   a. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No
      1. Chest pain upon exertion? .... Yes No
      2. Shortness of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
   b. Seasonal, environmental or food allergies .... Yes No
   c. Sinus trouble .... Yes No
   d. Asthma or hay fever .... Yes No
   e. Fainting spells or seizures .... Yes No
   f. Diabetes .... Yes No
   g. Hepatitis, jaundice or liver disease .... Yes No
   h. Frequent or recurring mouth sores .... Yes No
   i. Thyroid problems .... Yes No
   j. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
   k. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
   l. Stomach ulcer or hyperacidity .... Yes No
   m. Kidney disease .... Yes No
   n. Tuberculosis .... Yes No
   o. Persistent cough or cough that produces blood .... Yes No

p. Persistent swollen neck glands .... Yes No
q. Low blood pressure .... Yes No
r. Epilepsy or neurological disorder .... Yes No
s. Are you taking vitamins or homeopathic remedies .... Yes No
t. History of cancer .... Yes No
u. Any disease, drug or transplant operation that has depressed your immune system .... Yes No

9. Do you have an artificial (implanted) joint? .... Yes No
   If so, please list the joint with the date of surgery:

10. Have you had abnormal bleeding? .... Yes No
11. Do you have any blood disorder such as anemia? .... Yes No
12. Have you ever had treatment for a tumor or growth? .... Yes No
13. Do you smoke? .... Yes No
    If so, please check # of packs per day and list years of smoking: O one O two O three packs per day for ________ years
14. Have you had any serious trouble associated with previous dental treatment? .... Yes No
    If so, explain:

15. Do you have any other condition or disease you think the doctor should know about? .... Yes No
    If so, explain:

16. Are you wearing contact lenses? .... Yes No
17. Are you wearing removable dental appliances? .... Yes No
18. Do you wish to talk with the doctor privately about anything? .... Yes No

Women

19. Are you pregnant or trying to become pregnant .... Yes No
20. Do you have problems associated with your menstrual period? .... Yes No
21. Are you nursing? .... Yes No
22. Are you taking birth control pills? .... Yes No

Chief Dental Complaint:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold the surgeon, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:________________________ Patient's / Guardian's Signature:____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history:

Anesthesia Risk Assessment: ASA I II III

Date:________________________ Doctor's Signature:____

Medical History Updates:

Date	Comments	Signature
____________	______________________________	______________________
____________	______________________________	______________________
____________	______________________________	______________________

Stateline Oral & Maxillofacial Surgery, PC

FINANCIAL POLICY

Thank you for choosing us as your oral surgery care provider. We are committed to the delivery of compassionate surgical care. The following is a statement of our financial policy; you will need to read and sign this document prior to any treatment. Please feel free to contact our office with any questions regarding this policy.

Patient with insurance: Your insurance may only pay a portion of the cost of treatment at this office; that portion not covered by insurance is your responsibility and will need to paid on the date of service. Our office will collect an estimate of what is payable by you on each date of service; this estimate will be based upon information provided to us by the insurance company. Information received from the insurance company is not a guarantee of benefit or payment. Individual plan benefits, such as plan waiting periods, UCR levels and yearly maximums vary greatly from plan to plan. If the insurance company pays less than estimated, or denies the claim entirely, you will receive a statement to that effect and you will responsible to pay the remaining balance within 10 days. If the insurance company pays more than estimated, you will be sent a refund. As a courtesy to you, this office will submit a claim to the insurance company on your behalf, but you remain responsible for all charges.

Please bring all dental and or medical insurance information with you. Proof of insurance with a claims address must be provided or you will be responsible for all charges on the day of service.

Claims submitted to an insurance company but not paid become due and payable by you 60 days from the date of service.

It is your responsibility to obtain referrals required by your insurance company prior to your appointment. If you do not have an appropriate referral, you will be responsible for all charges or, at your request, we can reschedule your appointment so that you may obtain one.

Patient without insurance: Full payment is expected on the date of service unless prior arrangements with this office have been made.

Method of payment: Cash, Check, Visa, Mastercard, Discover and Care Credit. A $30 charge will be applied to the account for returned checks.

Minor patients and dependent students: Any patient less than 18 years of age is considered a minor. An adult or guardian must accompany the patient for treatment. The adult accompanying the minor is financially responsible for the account. In the event the parents are separated or divorced, the parent accompanying the minor is financially responsible, regardless of divorce decree. Financial settlement must be resolved between the parents.
Insured dependent patients, 19 years or older, will be considered self pay and charges will be due on the day of service unless proof of student status is provided at the time of service.

Scheduling: 48 hours advanced notice is required for the cancellation of an appointment. Failure to give adequate notice may result in a fee of $25. Missed appointments may result in dismissal from the office.

Authorization to release information: I hereby authorize Stateline Oral & Maxillofacial Surgery, PC to release information acquired in the course of examination and/or treatment for insurance claims processing and/or legal purposes.

Patient / Responsible party: ____ Date: __________________

Stateline Oral & Maxillofacial Surgery, PC

Consent for the use of Private Health Information

Our office operates in compliance with the United States Governments' Health Insurance and Accountability Act (HIPAA). To that end, we are required to establish policies that manage the distribution of personal health information (PHI). As a patient, you are required to consent to the professional use of PHI. Our office staff would be happy to answer any questions that you might have regarding our policies.

Our office reserves the right to change these policies in accordance with government standards. You may request an updated "Notice of Privacy Practices" at any time; patients of record will not be automatically informed of these changes.

Patient / Guardian affirmation:

As a patient of Stateline Oral & Maxillofacial Surgery, PC, I understand that my personal health information (PHI) may be used for treatment, payment or health care operations. A written policy regarding the use of PHI by this office is available at my request.

As a patient of Stateline Oral & Maxillofacial Surgery, PC, I do have the right to request that the use of my PHI be restricted. I understand that my request must be submitted in writing. If the practice of Stateline Oral & Maxillofacial Surgery, PC agrees to said restrictions, they will become binding.

As a patient, and in accordance with governmental policies, I may revoke this consent at any time.

Signed: ___________________________________ Date: _______________