Oral&Facial
SURGERY CENTER
of JOPLIN

PLEASE PRINT

PATIENT'S FULL LEGAL NAME: _____ ___ _____ **NICKNAME:** _____
First Name MI Last Name

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME: ( )_____ **CELL:** ( )_____ **WORK:** ( )_____

DOB: ___/___/_____ **AGE:**_____ **SEX:** ☐**Male** ☐**Female** **SSN#**____-____-_____ ☐**Single** ☐**Married** ☐**Widowed** ☐**Divorced**

EMPLOYER: _____ **EMAIL** _____

SCHOOL: _____ ☐ **FULL TIME** ☐ **PART TIME**

REFFERED BY: _____ **GENERAL DENTIST:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____
OUT OF HOUSEHOLD

HOME: ( )_____ **CELL:** ( )_____ **WORK:** ( )_____

FINANCIAL RESPONSIBILITY: ☐SELF ☐PARENT ☐SPOUSE ☐OTHER

NAME: _____ **DOB:** _____ **SS#**_____-_____-_____

ADDRESS: _____ **PHONE:**( )_____

EMPLOYER: _____

PRIMARY DENTAL: _____ **ID#**_____ **GROUP#** _____

POLICYHOLDER'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DOB:_____ **SS#**_____-_____-_____ **EMPLOYER:** _____

SECONDARY DENTAL : _____ **ID#**_____ **GROUP#**

POLICYHOLDER'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DOB:_____ **SS#**_____-_____-_____ **EMPLOYER:** _____

MEDICAL INSURANCE: _____ **ID#**_____ **GROUP#** _____

POLICYHOLDER'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DOB:_____ **SS#**_____-_____-_____ **EMPLOYER:** _____

AUTHORIZATION, RELEASE & ACKNOWLEDGEMENT OF PAYMENT- I authorize the doctor and other dentist or health care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper care. I authorize the taking of photographs, radiographs, and other diagnostic records before, during and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize Oral & Facial Surgery Center to release any information (via mail or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such dental/medical care to third party payers and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to Oral & Facial Surgery Center insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. **I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT WITHIN 90 DAYS OF SERVICES RENDERED ON MY BEHALF OR ON BEHALF OF MY DEPENDENTS REGARDLESS OF INSURANCE STATUS.**
HIPPA Notice of Privacy Practices has been made available to me upon request.

Signature of Patient/ Guardian _____ **Date:** _____
***Over Please**

Oral & Facial Surgery Center of Joplin - Medical History

Have you ever had any of these following illnesses?
Please check all that apply.

- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Angina
- ☐ Coronary Artery Disease
- ☐ Arrhythmia
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Other Lung Disease
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Epilepsy/Seizures
- ☐ Anemia
- ☐ Liver Disease
- ☐ HIV/AIDS
- ☐ Prosthetic Joints
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Hepatitis A B C D

Height _____"_____"

Weight: _____lbs

Do you smoke,
or use chewing tobacco?
If yes, how much?

_____

Do you drink alcohol?
If yes, how much?

_____

List and provide dates for all prior surgeries. ☐ None

_____
_____
_____
_____
_____

Do you take any medications regularly?
If so please list, including herbal, alternative and non-prescription medications. ☐ None

_____
_____
_____
_____
_____

	Yes	No
Have you been under the care of a physician in the last 5 years?	☐	☐

Are you allergic to any medications or foods?
(Penicillin, codeine, sulfa, aspirin, Novocaine, latex, eggs, soy) Yes ☐ No ☐

_____
_____
_____

	Yes	No
Are you taking or have you ever taken medication for osteoporosis, myeloma, breast cancer, or other bone disease? (Ex: Fosamax, Actonel, Boniva, Didronel, Aredia, Zometa, Reclast)	☐	☐
Have you ever had a artificial valve, replacement, or graft?	☐	☐
If yes, have you been instructed to take antibiotics prior to dental procedures?	☐	☐
Do you currently wear any oral appliances? (Ex: dentures, partials, retainers, spacers, etc)	☐	☐

Referring Dentist:

_____

Medical Physician:

_____

	Yes	No
Have you ever tested positive for Tuberculsis or any other infectious disease?	☐	☐
Do you tend to bleed or bruise easliy, or have a family history of bleeding disorders?	☐	☐
Do you suffer from chronic sinus or nasal problems?	☐	☐
Have you ever had a bad reaction to anesthesia, or do you have family history of anesthesia problems?	☐	☐
Have you ever been diagnosed with jaw joint (TMJ) problems?	☐	☐
Do you use marijuana, cocaine, methamphetamine, heroin, or other "recreational" or "street drugs"?	☐	☐
Do you have any other disease, condition or problem not listed, or do you wish to speak with the doctor privately about anything?	☐	☐

Female patients:

	Yes	No
Are you pregnant or suspect you may be pregnant?	☐	☐

If yes, how many weeks? _____

	Yes	No
Are you taking any birth control?	☐	☐
Are you aware that antibiotics may interfere with birth control pills?	☐	☐

To the best of my knowledge, all of the above is true and correct.
I understand that a complete and accurate medical history is important for my own safety when undergoing any surgical procedure.

Signature:_____ Date: _____
Patient, -Parent/Guardian if minor

***OVER PLEASE**

Oral&Facial
SURGERY CENTER
of JOPLIN

Consent for Disclosure of Health Care Information (HIPPA)

Patient's Name:_____ Date of Birth:____/____/_____

SSN: _____ Previous/ Maiden Name:_____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide healthcare to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclose of this information unless I permit it. However, I understand that the law may require the release of this information without my permission.

I can ask my doctor to limit how personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that my doctor and his staff can give me called
" Revocation of Consent for Use and Disclosure of Health Information"

2) Writing, signing, and dating a letter to my doctor directly. If I write a letter; it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the polices and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice". If I ask, my doctor and his staff will provide me with the most current "Notice" and the current "Notice" will always be posted in my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

_____ _____
Patient (or legally authorized individual) signature Date

_____
Relationship to patient (parent, legal guardian, etc.)

ORAL & FACIAL SURGERY CENTER OF JOPLIN
FINANCIAL POLICY

Thank you for choosing us as your oral and maxillofacial provider. We are providing the following information to help you understand our office financial policy. Addressing methods of payment for surgery will be part of you pre-operative appointment.

We require payment in full for our pre-operative exam regardless of insurance coverage, however, we are glad to file your claim for reimbursement as a courtesy to you. Every attempt is taken to verify your insurance benefits prior to your surgery appointment. Please note that a verification of benefits is **NOT** a guarantee of payment or promise of covered benefits. We encourage you to contact your insurance carrier to learn about your coverage and its limitations.

SURGERY PAYMENT OPTIONS

1. **Self-pay Patients Only**: A 10% discount is given when payment is made in full on the day of treatment via cash, check, debit card, or major credit card (Visa, MasterCard, American Express, and Discover).

2. **In-Network Insurance**: We require collection of your estimated portion (depending on the policy) when surgical charges are incurred. Yearly maximum benefit limits and deductibles will apply. Your insurance may have benefit limitations that do not cover the cost of some treatments, these costs will be the responsibility of the patient/guarantor.

3. **Out-of-Network Insurance**: We require collection of your estimated portion (depending on your policy) when surgical charges are incurred. Yearly benefit maximums and deductibles will apply. Please know benefits are based upon the terms and conditions of your insurance contract between your employer and the insurance company. Your insurance may have benefit limitations that do not cover all of the cost of some treatments. Those costs will be the responsibility of the patient/guarantor.

4. **Surgery Deposit:** We require half of your portion paid at the time your surgery appointment is scheduled.

5. **Medicare, Medicaid, Tricare/Champus, and ChampVA**: Patients with this insurance will be considered self-pay

6. **Payment Plan**: We offer a payment plan through CareCredit. Upon credit approval you may choose from several no interest and low interest payment options. Please feel free to contact our office or go to www.carecredit.com for more information. The application can be processed at your pre-operative exam or a minimum of one week prior to your surgery.

7. **Past Due Accounts**: Any balance remaining 90 days after date of service, regardless of pending insurance, is the patient/guarantor's responsibility.

8. **Third Party Litigation**: Litigation (lawsuits) can sometimes take years to settle. We do not bill attorneys for charges incurred for motor vehicle related injuries or injuries incurred in accident where third party is involved. We will provide your attorney with necessary medical records to settle your claim. The patient/guarantor will be considered self-pay.

9. **Failed Appointments: If you fail to show for your appointment or cancel it within 24 hours of your scheduled time a fee may be charged.**

***I have read and understand Oral & Facial Surgery Center's financial policy**

_____ _____

Signature of Patient / Guardian Date