Welcome to our Practice

PATIENT INFORMATION:

Registration Type: Patient

First Name: ___________________________ Middle Initial: __ Last Name: ___________________________________ Date: __/__/____

Birthdate: __/__/____ Soc. Sec. #: _____-____-______ Email: _______________________________________ Sex: ___________

Street 1: ____ Street 2: ____

Apartment #: _________________ City: _________________ State: ________ ZIP: ___________

Home Tel: ___________________ Mobile Tel: ____________________ Referred By: ___________________________________

Have you ever been a patient of our practice? Y / N Has a family member ever been a patient of our practice? Y / N

Referring Dentist: _______________________ Orthodontist: ______________________ Medical Dr.: _______________________

Preferred Pharmacy: ____________________ Tel: _______________________ Payment Type: Check / Credit / Cash

Preferred Pharmacy Address: ____ Tel: _________________________

Nearest relative not living with you: _______________________________________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Relationship: *(Please circle one. If self, skip this section)* Self / Spouse / Father / Mother / Other: ______________

First Name: ________________________ Last Name: _____________________

Birthdate: __/__/____ Soc. Sec. #: _____-____-______ Email: _______________________________________

Street 1: ____ Street 2: ____

Apartment #: _________________ City: _________________ State: ________ ZIP: ___________

Home Tel: ___________________ Mobile Tel: ____________________

Employer/Business Name: _____________________________ Business Phone: ____________________________

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE):

First Name: ________________________ Last Name: _____________________ Phone: ______________________________

Birthdate: __/__/____ Soc. Sec. #: _____-____-______ Email: _______________________________________

Street 1: ____ Street 2: ____

Apartment #: _________________ City: _________________ State: ________ ZIP: ___________

INSURANCE INFORMATION:

Employment Type: *(Please circle one)* Full Time / Part Time / Retired / Not Employed

Marital Status: *(Please circle one)* Single / Married / Divorced / Widow / Legally Separated

Student Status: *(Please circle one)* Full Time / Part Time / Not a student School Name: __________________________

PRIMARY DENTAL INSURANCE COMPANY:

Employer: ____

Tel.: ____________________ Plan: __________________

Ins. Co. Name: ___________________ ID #: ___________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

Ins. Tel.: _______________________

Group Name: _______________ Group #: _____________

Insured Party: _____________________________________

Relation: Self / Spouse / Father / Mother

Birthdate: ___/___/____ Soc. Sec. #: ______-_____-_______

Sex: M / F Tel.: ______________________________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: ____

Tel.: ____________________ Plan: __________________

Ins. Co. Name: ___________________ ID #: ___________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

Ins. Tel.: _______________________

Group Name: _______________ Group #: _____________

Insured Party: _____________________________________

Relation: Self / Spouse / Father / Mother

Birthdate: ___/___/____ Soc. Sec. #: ______-_____-_______

Sex: M / F Tel.: ______________________________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

SECONDARY DENTAL INSURANCE COMPANY:

Employer: ____

Tel.: ____________________ Plan: __________________

Ins. Co. Name: ___________________ ID #: ___________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

Ins. Tel.: _______________________

Group Name: _______________ Group #: _____________

Insured Party: _____________________________________

Relation: Self / Spouse / Father / Mother

Birthdate: ___/___/____ Soc. Sec. #: ______-_____-_______

Sex: M / F Tel.: ______________________________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

SECONDARY MEDICAL INSURANCE COMPANY:

Employer: ____

Tel.: ____________________ Plan: __________________

Ins. Co. Name: ___________________ ID #: ___________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

Ins. Tel.: _______________________

Group Name: _______________ Group #: _____________

Insured Party: _____________________________________

Relation: Self / Spouse / Father / Mother

Birthdate: ___/___/____ Soc. Sec. #: ______-_____-_______

Sex: M / F Tel.: ______________________________

Address 1: ____

Address 2: ____

City: ________________ State: ______ Zip: ___________

HEALTH HISTORY:

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason For Today's Office Visit ____________________

Height __________ Weight __________ Are you in good health? .... Y / N

Have there been any changes in your general health in the past year? .... Y / N

If so, describe ____________________

Are you under the care of a physician? .... Y / N

Date of last visit __________ If so, what are you being treated for? ____________________

Have you had any illness, operation, or been hospitalized in the past five years? .... Y / N

If so, describe ____________________

Do you have a prosthetic joint/implant? .... Y / N

If so, describe ____________________

Have you had a heart valve replacement or vascular graft? .... Y / N

If so, describe ____________________

Have you ever had general anesthesia? .... Y / N

If so, describe ____________________

Have you, or a family member, had any unusual or serious reactions to general anesthesia? .... Y / N

If so, describe ____________________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .... Y / N

If so, describe ____________________

Have you ever been diagnosed with autism or any other neurodevelopmental diagnosis? .... Y / N

If so, describe ____________________

Continued on next page.

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Rheumatic fever?.. Y / N
Damaged heart valves/mitral valve prolapse?........ Y / N
Heart murmur?.. Y / N
High blood pressure?.. Y / N
Low blood pressure?... Y / N
Chest pain / angina?... Y / N
Heart attack(s)?... Y / N
Irregular heart beat?... Y / N
Cardiac pacemaker?.. Y / N
Heart surgery?.. Y / N
Pneumonia, bronchitis or chronic cough?............... Y / N
Asthma?.. Y / N
Hay fever / sinus problems?.. Y / N
Snoring?... Y / N
Sleep apnea / CPAP?.. Y / N
Difficulty breathing / other lung trouble?............... Y / N
Tuberculosis?.. Y / N
Emphysema?.. Y / N
Do you smoke or vape?... Y / N
If so, how much per day?______________________
Do you use marijuana?... Y / N
Do you use chewing tobacco?..................................... Y / N
Blood transfusion?... Y / N
Blood disorder such as anemia?................................. Y / N
Bruise easily?.. Y / N
Bleeding tendency / abnormal bleed?...................... Y / N
Hepatitis, jaundice, or liver disease?........................ Y / N
Infectious mononucleosis?.. Y / N
Gallbladder trouble?.. Y / N
HIV / AIDS?.. Y / N

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Fainting spells?...Y / N
Convulsions / epilepsy?...Y / N
Stroke?..Y / N
Thyroid trouble?..Y / N
Diabetes?..Y / N
Low blood sugar?..Y / N
Kidney trouble?...Y / N
High cholesterol?...Y / N
Are you on dialysis?...Y / N
Swollen ankles, arthritis or joint disease?.................Y / N
Osteoporosis / osteopenia?..Y / N
Osteonecrosis?...Y / N
Stomach ulcers / acid reflux?..Y / N
Contagious diseases?..Y / N
Sexually transmitted diseases?.....................................Y / N
Problems with immune system?...................................Y / N
Delay in healing?..Y / N
A tumor or growth?..Y / N
Cancer, radiation therapy or chemotherapy?..........Y / N
Chronic fatigue / night sweats?....................................Y / N
Are you on a diet?..Y / N
A history of alcohol abuse?...Y / N
A history of marijuana or other drug use?................Y / N
Contact lenses?...Y / N
Eye disease / glaucoma?...Y / N
Mental health problems / anxiety / depression?.....Y / N
Removable dental appliance?..Y / N
Pain or clicking of jaws when eating?........................Y / N

WOMEN ONLY:

Is there a possibility of pregnancy?......................... Y / N
Are you Nursing?... Y / N
Date of your last period? __________________________
Expected delivery date? ____________________________
Are you taking birth control pills?................................ Y / N

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

Continued on next page.

ARE YOU ALLERGIC OR HAD A REACTION TO:

Local anesthetic (numbing medication) .... Y / N

Penicillin.. Y / N

Other antibiotics .... Y / N

Sulfa Drugs .... Y / N

Sodium pentothal, Valium, or other tranquilizers .. Y / N

Aspirin .... Y / N

Amoxicillin... Y / N

Codeine or other narcotics... Y / N

Latex.. Y / N

Soy.. Y / N

Eggs/Yolk .... Y / N

Sulfites.. Y / N

Do you have any known Allergies.............................. Y / N

Please list any allergies other than drug allergies:

____

Please list any other medications or antibiotics you are allergic to.

____
____
____
____

Family history of cancer?... Y / N

Family history of diabetes? .... Y / N

Family history of heart disease?.................................. Y / N

Family history of anesthesia problems?..................... Y / N

Family history of autism?... Y / N

Is there any condition concerning your health that the doctor should be told about?...................................... Y / N

Describe:______________________________________

____

Do you wish to speak to the doctor privately about anything? .... Y / N

Describe______________________________________

____

ARE YOU NOW TAKING:

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish oil)?............ Y / N

Have you ever taken diet pills?................................... Y / N

Any natural product, herbal supplement or homeopathic remedy? .... Y / N

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years ? .... Y / N

Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis ..... Y / N
If yes, please list:

____

____

If you are under the care of a physician for pain management, or recovering from drug addiction please circle the medication you are currently taking:

Methadone / Suboxone / Oxycodone / Fentanyl / Other
If Other, description:

____

Doctor name:___________________________________

Are you taking any kind of medication, drug, pills? Y / N

(If yes, list below)

Medication	Dosage	Frequency

Conclusion

Emergency Contact

First Name: ______________________ Last Name: _____________________ Home Tel: ______________________

Cell: _______________________ Relation: _____________________

Accident

Is this related to an accident? Y / N If yes, what type? ____________________________ Date of Injury ______________

Insurance company handling this claim: ______________________ Insurance Claim Number ______________________

Name of Attorney/Adjustor: __________________________________ Attorney/Adjustor Phone: ___________________

Review signature sections below, sign on page 7

Verification

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

Release of Information

This signature on file is my authorization for the release of information necessary to process my claim. Reimbursement will go to PT.

Financial Policy

Thank you for choosing Oral & Facial Surgeons of Ohio (Drs. Rekos, Border and Associates) for your oral & maxillofacial surgery needs. We are committed to providing the services you expect in a safe, friendly, and professional manner.

<u>Patients who do not have medical or dental insurance</u>

Payment is expected in full prior to the services being rendered.

<u>Patients who have verified medical and/or dental insurance benefits</u>

Co-pay is expected prior to the services being rendered and you will be responsible for anything not covered. As a courtesy to you, we will file a claim with your insurance carrier. Any credit due to you will be refunded or applied to future services. *This is an estimate. If you would like a predetermination of benefits from your insurance carrier, this can be arranged at your request and typically requires 4-6 weeks to be processed*

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. and Flexible Spending benefit cards or checks are acceptable.
- Care Credit is available for those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association approved commercial line of credit specifically designed for the payment of dental care. To learn more about this option, feel free to speak to the financial office.

PLEASE NOTE Financing options such as Care Credit are not available in conjunction with the courtesy discount and/or in-network dental plans

<u>Account Refunds</u>

Accounts reflecting a credit balance after insurance payment is received, change of treatment plan, etc. will be refunded via check. Refunds will be issued within 45 days of your account being finalized.

Please note the following:

- Any quoted fees are an estimate only and are valid for a period of 6 months.
- The financial obligation for services received is your responsibility and not the responsibility of Oral & Facial Surgeons of Ohio or your insurance carrier.
- We will file with your primary medical and primary dental insurance carrier. We will file to a secondary dental insurance carrier should a balance remain on the account after primary payment is received.
- Account balance is due within 30 days of the first statement received.
- In the event your account becomes delinquent, you may be responsible for any and/or all collection fees.

Authorization for Service

I authorize my surgeon and 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 to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

Notice of Privacy Practices

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

______________________________ Signature

______________________________ Date