South Dayton Oral & Maxillofacial Surgery

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7325 Far Hills Avenue
Dayton, Ohio 45459
(937) 439-1606

Patient Name (Dr. Mr. Mrs. Ms.)_____ Today's Date_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Birthdate_____ Age_____SS#_____-_____-_____Family Dentist_____

Employer/School_____Occupation/Student_____

Employer Address_____Phone_____

Guarantor_____ Payment Method: _____Cash _____Check _____Visa/MC/Disc.
(Check one or more) _____CareCredit _____Apply for Care Credit

Patient Relationship_____

Home Phone_____Cell Phone_____Email_____

Address (if different from patient)_____

Employer Name and Address_____

Work Phone_____ Occupation_____

Spouse Name_____ Spouse Employer_____

Work Phone_____ Occupation_____

Guarantor SS#_____-_____-_____ Spouse SS#_____-_____-_____

INSURANCE INFORMATION

Dental Insurance_____Policy#_____Phone_____
Policyholder_____Birthdate_____Employer_____
Secondary Dental_____Policy#_____Phone_____
Policyholder_____Birthdate_____Employer_____
Medical Insurance_____Policy#_____Phone_____
Policyholder_____Birthdate_____Employer_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon the completion of each visit. Other arrangements can be made with our office manager depending on 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, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

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 by your insurance company. Any unpaid balances after insurance are due within 30 days after payment is received.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named for the benefits otherwise payable to me. I have read the above and understand that I am responsible for all office charges. A 1.5% monthly service charge (18% APR) will be assessed on any unpaid balances after 30 days.

Signature_____ Date_____

Confidential Medical History

Physician's Name_____Date of last exam_____
Are you under physician's care currently?_____For what?_____
Women: Are you pregnant or currently trying to get pregnant?_____Nursing?_____Taking oral contraceptive?_____

List all **medications** you are presently taking:

_____
_____
_____
_____

Do you smoke?_____ How much?_____

List any **hospitalizations** or **surgeries**:

_____
_____
_____
_____

ALLERGIES: (Check one or more below)

____Penicillin ____Latex Other_____
____Aspirin ____Erythromycin _____
____Tetracycline ____Codeine _____
____ Dental anesthetics _____

SYMPTOMS: Check any symptoms you currently have or have had in the past.

General:

____Stomach/intestinal
____Fever blisters
____Cold sores
____Depression
____Dizziness
____Fainting
____Headache
____Migraines
____Ulcers
____Frequent diarrhea
____AIDS
____HIV positive
____Alzheimer's disease
____Osteoporosis
____Alcoholism
____Chemical dependency
____Psychiatric care
____Chemotherapy
____Cancer
____Radiation treatment
____Tumors/growths
____Weight loss
____Herpes
____Venereal disease
____Anorexia
____Bulimia
____Malignant hypothermia
____Bone Protecting Drugs

Cardiovascular:

____Chest pain
____Heart disease
____Heart attack/failure
____Irregular heartbeat
____Rheumatic fever
____Heart pacemaker
____High blood pressure
____Blood disease
____Bruise easily
____Bleeding disorder
____Congenital heart defect
____Heart murmur
____Mitral valve prolapse
____Angina
____Artificial heart valve
____Heart surgery
____Low blood pressure
____Anemia
____Blood transfusion

Muscle/Joint/Bone:

____Pain, numbness
____Facial pain/numbness
____TMJ pain/clicking
____Arthritis
____Artificial joints
____Fibromyalgia

Other:

_____
_____
_____
_____
_____
_____
_____

_____
Signature of patient (parent if minor) **Date**

Eyes, Ears, Nose, and Throat:

____Bleeding gums
____Hay fever
____Persistent cough
____Glaucoma
____Difficulty swallowing
____Loss of hearing
____Sinus problems
____Cataracts

Pulmonary:

____Obstructive sleep apnea
____Shortness of breath
____Asthma
____Chronic bronchitis
____Pneumonia
____Lung Disease
____Emphysema
____Tuberculosis
____Frequent cough

Nervous System:

____Convulsions
____Epilepsy/seizures
____Multiple sclerosis
____Stroke

Endocrine/Glandular:

____Goiter
____Kidney problems
____Kidney dialysis
____Liver disease
____Hepatitis A
____Hepatitis B
____Hepatitis C
____Thyroid disease
____Parathyroid disease
____Yellow jaundice
____Excessive thirst
____Diabetes
____Hypoglycemia
____Steroid use

Which pharmacy would you like to use?

Name:_____
Street/Zip:_____
_____

********For Office Use Only********

Medical history reviewed with patient:

Initials Date

Initials Date

Comments:_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer