**NOTE:** This form should not be completed in the browser, as your changes may not be properly saved. Please open a copy of it in a PDF editing tool, such as Adobe Acrobat, and fill it out on your computer.

## PATIENT INFORMATION:

Date____________________________

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name________________ M.I._____ Last Name__________________ Nickname_____________

**Sex:**☐Male ☐Female **Birth Date**:_______________ **Age**:______ **Soc. Sec. #** (*if patient a minor -skip*) _________-_______-_________

Email (for appointments/dental use only) ____________________________________________ (we don't sell/use for 3rd party)

Street __________________________________________ City __________________ State ___________ Zip ____________

Cell (_____) ___________________ Home Tel (_____) ________________________ Work (_____) ____________________

**Referring Dentist** _____________________ **Ref. Dent Phone #** _____________________ **Medical Doctor** __________________

For Emergencies: Nearest Relative not living with you______________________________ Tel. (______) _________________

Relationship to patient: ___________________________ **Preferred Form of Payment**: ☐ Cash ☐ Credit Card ☐ Care Credit

## PATIENT/GUARDIAN RESPONSIBLE FOR ACCOUNT:

**(If self, skip to next section)** ☐ Self ☐ Spouse ☐Father ☐ Mother ☐ Other _______________________

Name ________________________ S.S. # ____________________ Birth Date ____________ Age _______ Tel. (_____) ________________

Street _______________________________________________ City ____________________ State ____________ Zip _____________

Employer ____________________________________________________________ Bus. Tel. (_____) _______________________

## INSURANCE INFORMATION

**Student:** ☐ Full Time ☐ Part Time School Name/Address _______________________________________________

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ Other_______________________

**Employed:** ☐ Full Time ☐ Part Time ☐ Retired ☐ Home/Self Employed Employer__________________________

## PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name_____________________________________

Claims Address ____________________________________

__________________________________________________

Employer _________________________________________

Subscriber's Name__________________________________

Member ID # ___________________Group # ____________

Subscriber DOB _______________________

## PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name_____________________________________

Claims Address_____________________________________

__________________________________________________

Employer _________________________________________

Subscriber's Name__________________________________

Member ID #__________________Group#______________

Subscriber DOB _______________________

## SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name_____________________________________

Address __________________________________________

__________________________________________________

Employer ______________________________________

Subscriber's Name_________________________________

Subscriber DOB __________________

Sub. ID # ___________________Group # ________________

## SECONDARY MEDICAL INSURANCE COMPANY

Ins. Co. Name_____________________________________

Address __________________________________________

__________________________________________________

Employer ______________________________________

Subscriber's Name__________________________________

Subscriber DOB ____________________

Sub ID #_____________________Group#________________

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 medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for honestly answering all of the questions on this form. Your answers are strictly for our records and are considered confidential.

**Reason/area of concern for today's visit:** ____________________________________________________________

## Health History

| | 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? Date of last visit__________ | □ | □ |
| *If so, for what are you being treated?*______________________________ | | |
| 4. Have you had any illness, operation or been hospitalized in the past five years? | □ | □ |
| *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 a prosthetic joint/implant? *If so, describe where* | □ | □ |
| 7. Have you had a heart valve replacement or vascular graft? | □ | □ |

| HAVE YOU HAD OR DO YOU CURRENTLY HAVE… | Yes | No |
|---|---|---|
| 8. Rheumatic fever? | □ | □ |
| 9. Damaged heart valves/mitral valve prolapsed | □ | □ |
| 10. Heart murmur? | □ | □ |
| 11. High blood pressure? | | □ |
| 12. Low blood pressure? | □ | □ |
| 13. Chest pain/angina? | □ | □ |
| 14. Heart Attack(s)? | □ | □ |
| 15. Irregular heart beat? | □ | □ |
| 16. Cardiac pacemaker? | □ | □ |
| 17. Heart surgery? | □ | □ |
| 18. Bronchitis, chronic cough? | □ | □ |
| 19. Asthma? | □ | □ |
| 20. Hay fever/sinus problems? | □ | □ |
| 21. Snoring/sleep apnea? | □ | □ |
| 22. Difficult breathing/other lung trouble? | □ | □ |
| Possibly from medication / surgery, etc. | □ | □ |
| 23. Tuberculosis? | □ | □ |
| 24. Emphysema? | □ | □ |
| 25. Do you smoke? | □ | □ |
| 26. Do you use chewing tobacco? | □ | □ |
| 27. Blood transfusion? | □ | □ |
| 28. Blood disorder such as anemia? | □ | □ |
| 29. Bruise easily? | □ | □ |
| 30. Bleeding tendency/abnormal bleeding? | □ | □ |
| 31. Hepatitis, jaundice, or liver disease? | □ | □ |
| 32. Infectious mononucleosis? | □ | □ |
| 33. Gallbladder trouble? | □ | □ |
| 34. Fainting spells? | □ | □ |
| 35. Convulsions/epilepsy? | □ | □ |
| 36. Stroke? | □ | □ |
| 37. Thyroid trouble? | □ | □ |

| | Yes | No |
|---|---|---|
| 38. Diabetes? | □ | □ |
| 40. Low blood sugar? | □ | □ |
| 41. Kidney trouble? | □ | □ |
| 42. Are you on dialysis? | □ | □ |
| 43. Swollen ankles, arthritis or joint disease? | □ | □ |
| 44. Osteoporosis / Osteopenia? | □ | □ |
| 45. Osteonecrosis? | □ | □ |
| 46. Stomach ulcers? | □ | □ |
| 47. Contagious disease? | □ | □ |
| 48. Sexually transmitted diseases? | □ | □ |
| 49. HIV or AIDS? | □ | □ |
| 50. HEPITITIS A, B or C ? | □ | □ |
| 51. Are you immunosuppressed? | □ | □ |
| Possibly from medication / surgery, etc. | □ | □ |
| 52. Problems with the immune system? | □ | □ |
| 53. Delay in healing? | □ | □ |
| 54. A tumor or growth? | □ | □ |
| 55. Radiation therapy / chemotherapy? | □ | □ |
| 56. Chronic fatigue / night sweats? | □ | □ |
| 57. Are you on a diet? | □ | □ |
| 58. A history of drug abuse? | □ | □ |
| 59. A history of alcohol abuse? | □ | □ |
| 60. Contact lenses? | □ | □ |
| 61. Eye disease / glaucoma? | □ | □ |
| 62. Mental health problems? | □ | □ |
| 63. A removable dental appliance? | □ | □ |
| 64. Pain and clicking of jaws when eating? | □ | □ |
| 65. Malignant hyperthermia? | □ | □ |
| 66. **ARE YOU HAVING SURGERY TODAY** | □ | □ |

have you had anything to eat or drink in the last 6 hours? If Yes What?

________________________________________________________________

67. Who is driving you home? ______________________________________

| HAVE YOU HAD OR DO YOU CURRENTLY HAVE… | Yes | No |
|---|---|---|
| 68. Any kind of medication, drug, pills? | ☐ | ☐ |
| 69. Blood thinners (Coumadin, Plavix, Aspirin, vitamin E, Ginko Biloba)? | ☐ | ☐ |
| 70. Have you ever taken diet pills? | ☐ | ☐ |
| 71. Any natural product, herbal supplement or homeopathic remedy? | ☐ | ☐ |
| 72. Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)? | ☐ | ☐ |

73. Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis?

______________________________________________

______________________________________________

74. Please list any medications you are currently taking:

______________________________________________

______________________________________________

| Allergies – Are you allergic to, or had a reaction to…….. | Yes | No |
|---|---|---|
| 75. Local anesthetic (numbing medication)? | ☐ | ☐ |
| 76. Penicillin? | ☐ | ☐ |
| 77. Other antibiotics? | ☐ | ☐ |
| 78. Sulfa Drugs? | ☐ | ☐ |
| 79. Sodium pentothal, Valium, or other tranquilizers? | ☐ | ☐ |
| 80. Aspirin? | ☐ | ☐ |
| 81. Codeine or other narcotics? | ☐ | ☐ |
| 82. Other medication? | ☐ | ☐ |
| 83. Latex? | ☐ | ☐ |
| 84. Soy? | ☐ | ☐ |
| 85. Egg / Yolk? | ☐ | ☐ |
| 86. Sulfites? | ☐ | ☐ |

87. Please list any allergies other than drug allergies: ______________________________

______________________________________________

Is there any condition concerning your health that the Doctor should be told about?

☐ Yes ☐No *(If so, describe)* ______________________________

______________________________________________

Do you wish to speak to the Doctor privately about anything?

☐ Yes ☐ No

| Is there a Family History of: | | |
|---|---|---|
| Cancer | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Heart Disease | ☐ Yes | ☐ No |
| Anesthetic Problems | ☐ Yes | ☐ No |

**IS THIS VISIT RELATED TO AN ACCIDENT?**

| | | |
|---|---|---|
| Automobile | ☐ Yes | ☐ No |
| Work Related | ☐ Yes | ☐ No |
| Other | ☐ Yes | ☐ No |

Date of injury________________

Insurance Company handling this claim:______________________________

Claim Number:______________________________

Name of attorney / adjuster:______________________________

Tel. Number:______________________________

**THIS SECTION IS FOR WOMEN ONLY, MEN CONTINUE BELOW, WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.**

| | | |
|---|---|---|
| 88. Is there possibility of pregnancy? | ☐ Yes | ☐No |
| 89. Expected due date ______ / _______ / ________ | | |
| 90. Are you nursing? | ☐ Yes | ☐ No |
| 91. 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 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 deductible amount, co insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

______________________________________________

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 or 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.

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

Signature of patient: Date:

## Consent For Use & Disclosure Of Information For Purposes Requested By Oral Surgery

I hereby permit VESG to use my health information and/or to disclose my health information to my insurance company or to any party involved in my health care. I understand that there is a Notice of Privacy Practices available for me to read. This consent shall be in force and effect as long as I am a patient at this practice. I understand that I have the right to revoke this consent in writing, at any time, by sending such written notification to my doctor(s) at this practice.

I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights.
- Refuse to sign this consent

Patient, Parent or Responsible Party ______________________________________________ Date_____________________

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## Financial Agreement

- I understand that the responsibility for payment of dental services provided in this office for my dependents or myself is mine. Payment is due and payable at the time of services are rendered. In the event that any balance is not received, after my insurance has made payment, I understand that a 2% finance charge (20% APR) may be added to my account.
- Any unpaid insurance balances may be transferred directly to the patient/insured after 45 days.
- I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures that will not be covered.
- I understand that my dental care provider has a relationship with me and not my insurance company. I understand that my provider will file my insurance claims as a courtesy to me, but my provider cannot guarantee my insurance company will pay any claims and the whole amount is my responsibility regardless of any insurance payment.
- I understand that my provider accepts the following forms of payment: Cash, Visa, Master Card, American Express, Discover, Debit Cards and Care Credit.
- I understand that there will be a $35.00 insufficient funds fee to my account in the event of any returned or cancelled payment.
- I understand that in the event my account would need to be assigned to an outside collection agency, a collection fee up to 50% of the balance will be added to the account prior to assignment and is payable by me.
- I understand that my appointment time has been especially reserved for me and in the event that I need to reschedule, I will give a 24-business hour notice**.** Failure to do so will result in a cancellation fee.
- I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or the health history information.

Patient, Parent or Responsible Party ________________________________________________ Date____________________

# VESG

## HIPAA: ACKNOWLEDGMENT OF PRIVACY POLICY

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your dental treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent. You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request. We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

I authorize the following people to request and/or receive information about my dental care:

Name:__________________________________________________ Relation: _____________________ Date of Birth: ____________________

Name:__________________________________________________ Relation: _____________________ Date of Birth: ____________________

Patient, Parent or Responsible Party_____________________________________________________ Date:___________________________

## INSURANCE

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Insurance Protocol is important to our professional relationship. We must emphasize that our relationship is with you, not your insurance company. It is your responsibility to provide us with any and all changes that may occur regarding your insurance information.

Your insurance is a contract between you, your employer, and the insurance company. We will process your insurance claims as a courtesy to you with the information you provide us. **This will serve as signature on file for the submission of all insurance claims and assignment of benefit to the above named office.** Many services that are delivered in our practice (i.e.; cosmetic appliances) are not necessarily included in your insurance benefits. Therefore any difference in fees will be your responsibility. It is your responsibility to make sure payments are made in a timely matter. Please make sure our office is aware of any changes in your insurance coverage or carrier. If for any reason your insurance does not pay, it will be necessary for us to bill you directly for the charges. Any insurance account over 3 months past due will automatically be billed to you. Thank you for understanding our Insurance Protocol. If you have any questions about the above information, please ask us. We are here to help you.

1. I have read the above information. I understand and agree that I am responsible for the payment of all professional services rendered.
2. I authorize any and all payment from my insurance company directly to VESG, P.C.

3. I authorize the release of any medical information necessary to process your insurance claims.

Patient, Parent or Responsible Party: ________________________________________________________ Date:_______________________