PATIENT INFORMATION

DATE_____

LAST NAME_____ FIRST NAME_____ MI_____

GUARDIAN NAME(IF PATIENT IS A MINOR)_____

DATE OF BIRTH_____ AGE_____ SS#_____

ADDRESS_____ APT#_____

CITY_____ STATE_____ ZIP_____

HOME#_____ CELL#_____ WORK#_____

EMPLOYER_____ POSITION_____

BUSINESS ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMERGENCY CONTACT NAME_____ RELATIONSHIP_____ PHONE_____

NAME OF INSURED/POLICY HOLDER_____

POLICY HOLDER DATE OF BIRTH_____ POLICY HOLDER DL#_____

NAME OF DENTAL INSURANCE COMPANY_____ PHONE#_____

INSURANCE ADDRESS_____

MEMBER ID#/SS#_____ GROUP#_____

PERSONAL PHYSICIAN_____ PHONE#_____

PHARMACY NAME_____ PHONE#_____

PHARMACY ADDRESS_____

GENERAL DENTIST NAME/DENTAL OFFICE _____

ADDRESS_____ PHONE#_____

WHOM MAY WE THANK FOR THIS REFERRAL? NAME_____

ADDRESS_____ PHONE#_____

*I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY TREATMENT CLAIM

_____ _____

NAME OF PATIENT/LEGAL GUARDIAN (PRINT) RELATIONSHIP IF PATIENT A MINOR

_____ _____

SIGNATURE OF PATIENT/LEGAL GUARDAIN DATE

MEDICAL HISTORY FORM

Patient Name:_____ Sex:_____ Height:_____ Weight:_____ BMI:_____ Age:_____

Purpose of Visit:_____

Drug Allergies? ( ) Yes ( ) No *If yes, list name of drug and reaction that occurred

_____

Medications Taking: *List dosage, amount, and quantity taking per day

_____

_____

_____

Indicated which of the following you have, or have had in the past:

ADD/ADHD	( )Yes ( )No	Bruise Easily	( )Yes ( )No	High Cholesterol	( )Yes ( )No
AIDS/HIV Positive	( )Yes ( )No	Cancer/Tumor	( )Yes ( )No	Irregualar Heart Beat	( )Yes ( )No
Alzheimer's Disease	( )Yes ( )No	Chemo/Radiation	( )Yes ( )No	Kidney Problems	( )Yes ( )No
Anaphylaxis	( )Yes ( )No	Diabetes	( )Yes ( )No	Liver Problems	( )Yes ( )No
Anemia	( )Yes ( )No	Dialysis	( )Yes ( )No	Nervous Disorders	( )Yes ( )No
Angina/Chest Pain	( )Yes ( )No	Dizziness/Fainting	( )Yes ( )No	Organ Transplant	( )Yes ( )No
Anxiety/Depression	( )Yes ( )No	Drink Alcohol	( )Yes ( )No	Osteoperosis	( )Yes ( )No
Arthritis	( )Yes ( )No	Drug Use	( )Yes ( )No	Pace Maker	( )Yes ( )No
Artificial Hear Valve	( )Yes ( )No	Epilepsy/Seizures	( )Yes ( )No	Sinus Problems/Allergies	( )Yes ( )No
Artificial Joints	( )Yes ( )No	Eye Disease	( )Yes ( )No	Steroid Treatment	( )Yes ( )No
Asthma	( )Yes ( )No	Heart Attack	( )Yes ( )No	Stomach Problems	( )Yes ( )No
Autism	( )Yes ( )No	Heart Mumur	( )Yes ( )No	Stroke	( )Yes ( )No
Bleeding Disorder	( )Yes ( )No	Heart Problems	( )Yes ( )No	Taken Bisphosphonate	( )Yes ( )No
Blood Transfusion	( )Yes ( )No	Hepatitis	( )Yes ( )No	Thyroid Disorder	( )Yes ( )No
Breathing Problems	( )Yes ( )No	Herpes	( )Yes ( )No	Tuberculosis	( )Yes ( )No
Bronchitis	( )Yes ( )No	High Blood Pressure	( )Yes ( )No	Tobacco Use	( )Yes ( )No

**Female Patients:
Pregnant/Trying to Conceive ( )Yes ( )No Taking Oral Contraceptives ( )Yes ( )No Nursing ( )Yes ( )No

Surgeries/Hospitalizations: ( )Yes ( )No **If yes, please list reasons/dates

_____

_____

Any Complications with Medical/Dental Treatments: ( )Yes ( )No **If yes, please explain

_____

Are you under a Doctor's care now?(Other than Primary Care Physician) ( )Yes ( )No
*If yes, please list name and phone number_____

Do you have any other information that you think we should know about? ( )Yes ( )No
*If yes, please explain_____

DENTAL HISTORY

Does your mouth hurt now? ( )Yes ( )No	Sensitivity to Hot/Cold? ( )Yes ( )No	Fever Blisters? ( )Yes ( )No
Do you grind your teeth? ( )Yes ( )No	Jaw Joints Hurt/Pop? ( )Yes ( )No	Ortho(Braces)? ( )Yes ( )No

I understand and have answered all of the above questions to the best of my ability and I consent to x-rays and photos to be used for diagnostic and teaching purposes.

_____ _____

Patient/Guardian Signature Date

OFFICE AND FINANCIAL POLICIES

Welcome and Thank You for choosing Dr. Remedios for your Oral Surgery care. We are committed to providing you with the highest quality care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration with your time as our patient.

Initials: _____ **Insurance:** The patient is responsible for knowing their dental insurance information including insurance company name and ID number. The patient is responsible for knowing their insurance benefits including their deductible and out-of-pocket expense. Deductibles and Patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. Quotes we give you are estimates only-Insurance companies do not guarantee benefits until they actually process the claim. An estimate is not a guarantee of full payment for services rendered. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the estimated amount on the day of surgery, and any amount not paid for, or covered by your insurance company after the claim has been processed. Patient is overall responsible for timely payment on their account.

Initials: _____ **Cancellations:** Please be advised that we have an office policy concerning broken appointments in our office. This includes: No Shows and Last Minute Cancellations for SCHEDULED SURGERIES ONLY. There will be a $100.00 fee charged for not showing for Surgical Appointments and/or cancelling less than 48 hours prior to your scheduled appointment. This time is requested to allow us to schedule another patient in that time slot. **Note: We DO have an after hours answering service to leave messages-including weekends.** Emergency situations for cancellation will be considered at the office manager's discretion for fee to be waived. This policy is enforced to respect the time of Dr. Remedios, staff, as well as other patients.

Initials: _____ **Patient Balances:** Please be prepared to pay the current visit as well as any past balances on your account. Payment for Deductible, Out-of-pocket expense, and non-covered services will be required at the time of service. For your convenience we take, cash, credit cards, and money orders. **NO CHECKS WILL BE ACCEPTED**

Initials: _____ **Late Arrivals:** We do our best to have less patient wait time, but when a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule your appointment to keep our schedule on time. This policy is enforced to respect the time of Dr. Remedios, staff, as well as other patients.

Initials: _____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records. Otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you WILL NOT be seen until the account is paid in full to the collection agency.

Initials: _____ **Prescriptions:** Prescriptions for pain medicine cannot be called in as per Rx regulations. Please be aware that prescriptions will not be given after hours, as they have to be electronically submitted.

I have read, understand, and agree to the above Office and Financial Policies. I hereby attest that I have given and agree to provide current demographics and insurance information, and authorize release of information necessary for insurance filing and billing by signing this statement.

Patient/Guardian name(print): _____ Date of Birth: _____

Patient/Guardina signature: _____ Date: _____

Medical Center Oral Surgery
Dr. B. L. Remedios, DDS

HIPPA Privacy Authorization Form

This form is used for authorization for use or disclosure of PHI, Protected Health Information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient/Guardian Name:_____

Patient/Guardian Date of Birth:_____

I _____ (name) authorize Medical Center Oral Surgery permission to all of my dental/health care, and dental/medical service providers and payers to disclose and release my protected health information. I also allow Medical Center Oral Surgery to give my clinical information to, or answer questions from:

Name(s):	Relationship:	Phone Number:

This information may be used to enable the person(s) I authorize, to know and understand my condition and my treatment for post-operative care, claims, payment purposes, or related reasons to my dental/medical care.

Please note all forms of communications our office may use to contact you:

- Home/Cell/Work phone calls
- Leaving detailed messages
- Written Communication
- Mail to Home/Office address
- Fax or Email if provided

An individual is provided the right to request confidential communications or that a communication of PHI be made by alternative means. Please let our office know if alternative means are needed.

_____ _____

Signature of Patient/Guardian Date