PATIENT REGISTRATION & INSURANCE INFORMATION

Welcome to our office. To assist in your treatment, please provide us with the information requested below. All information is kept confidential.

PATIENT INFORMATION

Patient's Name: ______________________________________ Age: ______ Date of Birth: _____________________

Male/Female Social Security: ______________________________________ Single/Married/Divorced/Other

Address: ____ City: _______________________ Zip: __________

Home Phone: ________________________ Cell: _____________________ Work: ____________________________

E-Mail: ____

Preferred Pharmacy: ____________________________ Preferred Method of Billing: ☐ Email ☐ Mail

Referring Dentist: ____________________ Orthodontist: _________________ Are you currently in pain? Yes / No

Reason for Visit: ____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Responsible Party's Name: ________________________________Relationship to Patient: _____________________

Social Security: ____________________ Phone: _______________________ Employer: ______________________

Address: ____City: _______________________ Zip: _________

Insurance Company: _____________ Subscriber's Name: ___________________________Date of Birth: ________

Phone: _______________________ID #: _________________________________ Group #: ___________________

Employer: ________________ Subscriber's Address: ____

______________________________________ ____________ ____
Patient Signature (or legally authorized individual) Date Relationship to patient (parent, legal guardian, etc.)

Patient's Name ____ **Date of Birth:** ______________________

INSURANCE

For patients with indemnity carriers and reimbursement programs, we will bill your insurance as a courtesy. This contract is between you and your insurance company, and you are fully responsible for any amount not paid by your insurance. We do not guarantee that your insurance will pay. We will perform our routine insurance billing procedures but, if your insurance claim is denied, **you are responsible for the full balance of your bill within 30 days of notice of denial.** We will not enter into a dispute with your insurance company over denied claims. This is your responsibility and obligation. We always get the best insurance information available to us to estimate your amount due for treatment. If you desire a written preauthorization from your insurance company to guarantee coverage, please let us know. These preauthorizations usually require 6-8 weeks to return from the insurance company.

If we have not received payment from your insurance company within 60 days of service, the balance becomes your responsibility.

For our patients with HMO or DMO coverage, we are preferred providers and have approved fees for those services under our agreement with the carrier. We are only authorized to perform those services agreed upon. Should you and our office mutually decide to perform and receive services outside our contract with the carrier, you will be responsible for payment of the fees.

Payment is due on the day of surgery.

______**Initials** By initialing, I acknowledge that I have read and understand the above regarding insurance.

MEDICARE/MEDI-CAL/MEDICAID

Our doctors are not providers for Medicare, Medi-Cal or Medicaid. We are happy to examine and treat you, but be advised that the total bill is your responsibility. We will not bill Medicare, Medi-Cal or Medicaid for you. Fees are due in full at the time of service. I have read the above statement and still desire treatment. I agree that I will not try to get reimbursement from Medicare and do not expect Ocean Oral and Maxillofacial Surgery to bill for me. I assume full financial responsibility for all charges for my care.

______**Initials** By initialing, I acknowledge that I have read and understand the above regarding Medicare.

X-RAY SERVICES

Digital panoramic X-Ray or cone-beam CT may be necessary for the complete diagnosis and treatment of your case. These X-Rays are mandatory for medical-legal and insurance purposes. We will bill your insurance but make no guarantee of payment. If your insurance denies payment of any X-Ray, you are financially responsible. We do not take unnecessary X-Rays. Unclear or old X-Rays (older than six months) are not adequate for surgical purposes.

______**Initials** By initialing, I acknowledge that I have read and understand the above regarding X-Rays.

APPOINTMENTS

The doctors spend a great deal of time with each patient. The doctors' and other patients' time is precious. Please be courteous and if you must reschedule your appointment, please do so only with a 72-hour notice. There is a $250.00 charge for any surgery appointments cancelled without a 72-hour notice.

____ ____________ ____

Patient Signature (or legally authorized individual) Date Relationship to patient (parent, legal guardian, etc.)

Medical History

Name: ____ Date: __________________________
Date of Birth: __________ Sex: M / F Height: __________ Weight: ________________________

For the following questions, circle yes or no. Your answers are for our records only and are kept confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on _____________________________________.
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? ____
5. My physician's name and address is: ____
   ____
6. Have you had any serious illness, operation or hospitalization within the past five years? .... Yes No
7. Have you had an artificial joint re placement (knee, hip, shoulder, etc.)? .... Yes No
8. Are you taking or have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? .... Yes No
9. Are you taking any medicine including diet pills, non-prescription, vitamins, homeopathic or natural remedies?
   If so, please list: ____ Yes No
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur .... Yes No
    b. Rheumatic heart disease .... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? .... Yes No
       i. Chest pain upon exertion? .... Yes No
       ii. Shortness of breath after mild exercise? .... Yes No
       iii. Do your ankles swell? .... Yes No
    d. Allergies .... Yes No
    e. Sinus trouble .... Yes No
    f. Asthma or hay fever .... Yes No
    g. Fainting spells or seizures .... Yes No
    h. Diabetes .... Yes No
    i. Hepatitis, jaundice or liver disease .... Yes No
    j. Frequent or recurring mouth sores .... Yes No
    k. Thyroid problems .... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
    n. Osteoporosis .... Yes No
    o. Stomach ulcer or hyperacidity .... Yes No
    p. Kidney trouble .... Yes No
    q. Tuberculosis .... Yes No
    r. Persistent cough or cough that produces blood .... Yes No
    s. Persistent swollen neck glands .... Yes No
    t. Low blood pressure .... Yes No

u. Epilepsy or neurological disorder .... Yes No
v. Cancer .... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system? Yes No

11. Have you had abnormal bleeding? .... Yes No
    Have you ever required a blood transfusion? .... Yes No
12. Do you have any blood disorder such as anemia? .... Yes No
13. Have you ever had treatment for a tumor or growth? .... Yes No
14. Have you had radiation therapy to the head, neck or jaws? .... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics .... Yes No
    b. Penicillin or antibiotics .... Yes No
    c. Sulfa drugs .... Yes No
    d. Barbiturates or sleeping pills .... Yes No
    e. Aspirin .... Yes No
    f. Iodine .... Yes No
    g. Codeine or other narcotics .... Yes No
    h. Latex or rubber products .... Yes No
    i. Intravenous anesthesia .... Yes No
    j. Other ______________________________
16. Have you had any serious trouble associated with previous dental treatment? .... Yes No
    If so, please explain: ______________________________
    ____
17. Do you have any other condition or disease you think the doctor should know about? Yes No
    If so, explain: ______________________________
18. Do you smoke or chew tobacco? .... Yes No
    How much/often? ______________________________
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? .... Yes No
20. Are you wearing contact lenses? .... Yes No
21. Are you wearing removable dental appliances? .... Yes No
22. Do you wish to talk privately with the doctor about anything? .... Yes No

Women

23. Are you pregnant or trying to become pregnant? .... Yes No
24. Do you have problems associated with your menstrual period? .... Yes No
25. Are you nursing? .... Yes No
26. Are you taking birth control pills? .... Yes No

Chief Dental Complaint: ______________________________
____

I have read and understand this form. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to complete this form honestly and completely.

Patient's Signature ______________________________ **Date** ____________________

Doctor's Signature ______________________________ **Date** ____________________

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

We are required by law to keep your health information secure and confidential. Also by law we need to give you this notice and to follow the terms of this notice. We are permitted to use or disclose your health information to those involved in your treatment. For example, we may have a doctor whom we involve in your care review your case. We may use or disclose your health information for payment of services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for normal healthcare operations. For example we may enter your treatment information into our computer system.

We may share your medical information with business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.

In an emergency we may disclose your health information, when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose some or all of your health information. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will use whatever communication method, number or system you prefer. You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you wish to see. If you want a copy of your records, we may charge you a reasonable fee for copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to accommodate your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information. You have the right to receive a report of people to which we disclose your information. If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of changes in writing.

You may file a complaint with the Department of Health and Human Services in writing at 200 Independence Avenue SW, Room 509F, Washington, DC 20201, online at www.hhs.gov or by email at OCRComplaint@hhs.gov. You will not be retaliated against for filing a complaint. Please contact our Privacy Officer, Ann Becker, at 805.682.0933 for more information, to make a request, fine a complaint or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of Ocean Oral and Maxillofacial Surgery's Notice of Privacy Practices.

Signed ____________________________ Date ____________ Print Name ____________________________________

If signing as a parent or guardian, patient's name ____