PATIENT REGISTRATION

Oral & Facial Surgery of East Alabama

(Mr Mrs Ms Dr) First Name_____ M.I.____ Last Name_____ Nickname_____

Gender: M / F Age____ Date of Birth____/____/_____ Social Security Number _____-_____-_____

Home Address_____ City _____State _____ Zip _____

Home Phone (___) _____-_____ Work Phone (___) ____-_____ ext.____ Cell Phone (___) ____-_____

Employment: □ Full time □ Part time □ Retired □ Unemployed □ Disabled

Name of Employer _____

Student: □ Full time □ Part time

Name of School _____

Marital Status: □ Single □ Married □ Other

Emergency Contact _____ Relation _____ Phone Number (___) _____-_____

Your physician _____ Your dentist's name_____

Other dental specialists that you see_____ Who referred you to this office? _____

Name(s) of any family/friends who have been a patient here_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for treatment? □ Self □ Spouse □ Father □ Mother □ Other: _____

Guarantor_____ Social Security#_____ Driver's License#_____

Address_____ City/State/Zip_____ Home Phone (___)_____

Employer_____ Work(___)_____Ext____ Cell(___)_____Date of Birth _____

Name of Primary Dental Insurance Company _____

Name of Primary Medical Insurance Company _____

Insured Party Name _____ Date of Birth _____/_____/_____ SS#_____-_____-_____

FINANCIAL POLICY

PAYMENT

We accept cash, personal checks and credit cards (Visa, MasterCard and Discover). Please be aware that in case of a returned check, a $30 charge must be collected in order to cover the cost that is incurred from our bank. Payment in full is required for all consultation appointments (including x-rays). Insurance benefits will be verified before treatment and patient/guarantor notified of any changes to the estimate of your portion due at time of surgery.

A COURTESY FOR YOU

It is our pleasure to file insurance claims as a courtesy to our patients. Please be aware that this courtesy requires a significant amount of time and expense on the part of our staff. In return, we ask for your patience and cooperation when dealing with your insurance company. Upon your request, we will submit a printed predetermination of benefits; however, be aware that it takes (on average) 4 to 6 weeks to receive a response.

A MATTER OF RESPONSIBILTY

Professional services are delivered and charged to the patient, not to an insurance carrier. Though we will make every effort to assist you in claiming your benefits, please understand that the total service fee is due from you within 60 days of the date of treatment. We cannot accept final responsibility for collection of your insurance benefits as we are not a party to your insurance contract. A 1.5% service charge (18% annually) is added to any balance over 60 days old. There may be either an account balance or credit due to you upon completion of treatment. Refund checks are issued from this office on a weekly basis. Attorney and collection fees incurred in an effort to enforce payment by this agreement will be paid by the delinquent payer; whose failure to pay required such costs and services to be incurred.

I have reviewed this financial policy and understand that I am ultimately responsible for paying for treatment.

Authorization, **assignment**, **and release**: I hereby authorize Dr. Fuqua, Dr. Smith, Dr. Zouhary and/or his office staff to release any of my medical information required for payment or insurance claim(s) review. I authorize that my insurance benefits be paid directly to OFS for surgical services rendered. I acknowledge that I am financially responsible for all costs of treatment, including any balance unpaid by insurance.

_____ _____ _____

Signature of Patient (or Parent/guardian/guarantor if patient is less than 19 years old) Staff signature Date

Authority for the use of disclosure of my Protected Health Information (PHI)

I ALLOW access or disclosure to part or all of my medical records to the following people: (example: spouse, parent, guardian, etc…..)

List the names: _____

The people listed above have permission to access or disclose the following information contained in my medical record: (Please check)

Anything in my record _____ Lab Results _____

Physician notes _____ Information related to my surgery _____

Patient Printed Name:_____ Date of Birth:_____Patient Signature _____

HEALTH HISTORY

For your safety, it is necessary that you answer all of the following questions. (This information is strictly confidential.)

Patient name_____ Date _____/_____/_____

Height_____ Weight_____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

(Circle each item)			(Circle each item)			(Circle each item)		
Recent illness (within one year)	Y	N	Hemophilia	Y	N	Kidney problems	Y	N
Cough, cold, flu (within one week)	Y	N	Bruise or bleed easily	Y	N	Blood vessel grafts	Y	N
Nose obstruction	Y	N	Heart problems or chest pains	Y	N	Sexually Transmitted Disease	Y	N
Shortness of breath	Y	N	Heart Attack	Y	N	Diabetes	Y	N
Epilepsy or seizures	Y	N	Irregular heart beat	Y	N	Thyroid Disease	Y	N
Fainting or dizziness	Y	N	Hypertension (high blood pressure)	Y	N	AIDS/HIV positive/ARC	Y	N
Depression	Y	N	Rheumatic Fever	Y	N	Arthritis	Y	N
Psychiatric treatment	Y	N	Heart murmur	Y	N	Painful joints (including jaw)	Y	N
Stroke	Y	N	Mitral valve prolapse	Y	N	Prosthetic joint(s)–artificial	Y	N
Glaucoma	Y	N	Congenital heart lesions	Y	N	Hives (allergic rash)	Y	N
Cold sores (herpes)	Y	N	Prosthetic heart valve (artificial)	Y	N	Steroid medication(s)-Cortisone	Y	N
Persistent cough	Y	N	Pacemaker	Y	N	Drug addiction	Y	N
Emphysema	Y	N	Blood transfusion	Y	N	Alcoholism	Y	N
Tuberculosis/PPD positive	Y	N	Liver disease (Cirrhosis)	Y	N	Unexplained weight change	Y	N
Asthma	Y	N	Yellow Jaundice	Y	N	Depressed immune system	Y	N
Bronchitis	Y	N	Hepatitis	Y	N	Cancer/radiation therapy	Y	N
Sinus problems	Y	N	G-6PD deficiency	Y	N	Headaches (Migraine)	Y	N
Anemia	Y	N	Stomach Ulcers or Colitis	Y	N	Eating disorder	Y	N
Sickle Cell Disease	Y	N	Obstructive Sleep Apnea (CPAP)	Y	N	Anxiety	Y	N

Do you have a disease, condition, or health problem that is not listed above? **Y or N** If yes, please describe:

_____

Do you have any known drug allergies? **Y or N** If yes, please list: _____

Do you have a latex allergy? **Y or N**

Do you have any food allergies (eggs, soybeans, seafood)? If yes, please list:_____

Are you using any regular prescription medicine, pills, or drugs? **Y or N** If yes, please list:_____

_____

Have you ever taken biphosphonates such as fosomax, boniva, or reclast? **Y or N** If yes, please list: _____

Have you had any previous surgeries or operation? **Y or N** If yes, please list the name of the operation(s):

_____

Describe any past complications/difficulties with anesthesia: _____

Do you smoke tobacco products? **Y or N** If yes, at what age did you start? _____

Do you consume alcohol products? **Y or N** If yes, please circle one: □ mild □ moderate □ daily

Do you now/have you ever used recreational drugs **Y or N**? (Please circle): Cocaine, Marijuana, other _____

Do you have any **Family History** of:

Heart Disease	Y or N	Stroke	Y or N
Seizures	Y or N	Anesthesia Complications	Y or N
Bleeding Disorders	Y or N	Other_____	

For women only:

Are you, might you be, or are you trying to become pregnant? Y or N

If pregnant, approximately how many months? _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold OFS or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I certify that I read and understand the English language.

_____ _____ _____

Signature of Patient (and parent/guardian/guarantor if patient less than 19 years old) Staff signature Date