Patient Intake Form

Oral & Facial Surgery

☐ Mr ☐ Mrs ☐ Ms ☐ Dr First _____ MI ___ Last _____ Nickname _____
☐ Male ☐ Female | Social Security Number _____ Date of Birth ____ / ____ / ____ Age _____
Address_____ Height _____ Weight _____
City _____ State _____ Zip _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Marital Status ☐ Single ☐ Married Spouse's Name _____ Driver's License # _____
Family/friends who have been a patient here _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Employment

Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Disabled ☐ Other _____
Employer _____ Occupation _____

Education

Student Status ☐ Full Time ☐ Part Time ☐ Other _____ Current Grade Level _____
School _____

Referral

General Dentist _____ Orthodontist _____
Primary Care Physician _____ Other Healthcare Providers _____
Pharmacy _____ Pharmacy Phone _____

Guarantor

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Parent ☐ Other _____ Employer _____
Guarantor _____ DOB _____ SSN _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Primary Dental Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____
Primary Medical Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____
Secondary Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____

How did you hear about us ☐ Dentist | ☐ Friend/Family | ☐ Facebook | ☐ Print Ad | ☐ Internet Search
☐ Insurance | ☐ Other _____

I have read and understand the questions and information I provided above and on the Patient Health History following. I acknowledge that my questions, if any, about the inquiries concerning my information and/or my health history have been answered to my satisfaction. I will not hold OFS, LLC or its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Patient/Guardian Signature Date Staff Signature Date

Patient Health History

Past Medical History (for your safety, you must answer all of the questions below to the best of your knowledge)

Do you have any known drug allergies? ☐ Yes ☐ No | list _____

Do you have a Latex allergy? ☐ Yes ☐ No | Do you have any food allergies? ☐ Yes ☐ No | list _____

Please list ALL home medications (prescriptions, over the counter medicines, vitamins, herbal/dietary supplements)

_____

_____

Are you taking now or have you ever taken:

- Blood thinners (Warfarin, Coumadin, Xarelto, etc) Y | N List _____ Date last taken ____/____/____
- Bisphosphonate (Fosomax, Boniva, Reclast, etc) Y | N List _____ Date last taken ____/____/____
- Steroids (Prednisone) Y | N List _____ Date last taken ____/____/____
- Birth control pill or hormone replacement therapy Y | N List _____ Date last taken ____/____/____

Are you pregnant or are you planning to become pregnant within the next year? ☐ Yes ☐ No

Do you have any chronic medical problems?

Y | N High Blood Pressure	Y | N Pacemaker	Y | N Gastric Reflux	Y | N Diabetes	Y | N Anemia
Y | N Heart Disease	Y | N Rheumatic Fever	Y | N Stomach Ulcer	Y | N Thyroid Disease	Y | N Sickle Cell
Y | N Heart Failure	Y | N Stroke	Y | N Liver Disease	Y | N Glaucoma	Y | N Bleeding Problems
Y | N Heart Attack	Y | N Seizures/Epilepsy	Y | N Hepatitis	Y | N Herpes (cold sores)	Y | N Depression
Y | N Irregular Heart Beat	Y | N Sinus Problems	Y | N G-6PD	Y | N HIV/AIDS	Y | N Mental Illness
Y | N Heart Murmur	Y | N Sleep Apnea	Y | N Kidney Disease	Y | N STD	Other _____
Y | N Congenital Heart	Y | N Asthma	Y | N Arthritis	Y | N Migraine	Other _____
Y | N Valve replacement	Y | N Emphysema	Y | N Artificial Joint	Y | N Cancer/Radiation	Other _____

Past Surgical History

Please list all prior surgeries and any associated complications

_____

_____

Anesthesia History

Is there a personal or family history of anesthetic complications ☐ Yes ☐ No | Malignant Hyperthermia ☐ Yes ☐ No

Explain _____

Family History (please check all that apply)

Do you have a family history of any medical problems?

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Liver Disease ☐ Diabetes ☐ Bleeding Problems

☐ Obstructive Sleep Apnea ☐ Lung Disease ☐ Seizures ☐ Kidney Disease ☐ Thyroid Disease ☐ Psychiatric Diagnosis

Social History

Do you or have you ever smoked tobacco products? ☐ Yes ☐ No If yes, packs/day _____ for _____ years

Do you drink alcohol? ☐ Yes ☐ No If yes, please check? ☐ Occasional ☐ Moderate ☐ Daily

Do you or have you used recreational drugs? ☐ Yes ☐ No List _____

Review of Systems (please check all that apply)

☐ Fever/chills ☐ Weight loss ☐ Swollen lymph nodes ☐ Easy bruising/bleeding ☐ Oral/Facial Pain ☐ TMJ Pain ☐ Rash

☐ Pain or difficulty swallowing ☐ Chest pain ☐ Irregular heartbeat ☐ Shortness of breath ☐ Nausea/vomiting

☐ Facial weakness or numbness ☐ Memory loss/confusion ☐ Frequent infections ☐ Change in vision ☐ Headache

☐ Difficulty urinating ☐ Excessive thirst Other _____

_____ _____ _____ _____

Patient/Guardian Signature Date Staff Signature Date

Financial Policy

Thank you for choosing OFS, LLC. We are dedicated to providing exceptional care of our patients and their loved ones. We ask that you read this document thoroughly before signing. We will be glad to answer any questions you may have regarding the information provided here.

Payment

- Just as we make every effort to accomodate you when you are in need of medical/dental care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office.
- You must present a current insurance card and valid identification at each visit. If you do not present a current insurance card, you will be responsible for payment in full at the time of your visit. You will receive reimbursement from OFS, LLC if your insurance pays the claim at a later date.
- Co-payments, deductibles, and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Payment is expected within 10 days of receipt of your statement.
- If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans consider some services to be "non-covered," in which case you are responsible for payment in full.
- Self-pay patients should be prepared to pay his/her balance in full at the time of service.
- For your convenience we accept cash, personal checks, and credit cards (Visa, MasterCard, American Express, and Discover). We also accept Care Credit (a medical/dental financing option) and can help you see if you qualify. Payment in full is required for all surgeries and consultations at time of service (including x-rays and CT scans).
- Outstanding balances or failure to pay co-payments upon check-in may result in reschedule of non-emergent appointments.

Refunds

- 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 bimonthly basis. If you feel a refund is due, please contact our billing office.

Insurance

- Professional services are delivered and charged to you the patient not to your insurance carrier. Your health and/or dental insurance policy is a contract between you and your health insurance company or employer. We cannot accept final responsibility for collection of your insurance benefits as we are not a party to your insurance contract.
- Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
- Our doctors belong to many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your insurance carrier is not one with which we participate, you are responsible for payment in full at time of service.
- Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is rendered you will be responsible for the cost of care. When in doubt, contact your plan directly for clarification.
- As a courtesy and for your convenience, we do file insurance claims on your behalf. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. Please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered by OFS, LLC.
- Pursuant to Alabama Law, insurers are required to pay a properly submitted claim within 45 days. You have a responsiblity to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, the balance will be transferred to your account and you will be responsible for payment in full. If we receive payment at a later date, you will be reimbursed.
- When possible, insurance benefits will be verified before treatment and patient/guarantor will be notified of any changes to the estimate of your portion due at time of surgery. If we contact your insurance carrier regarding benefitis or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.
- Please be aware that this requires a significant amount of time on the part of our staff. We ask for you 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.

Financial Policy

Laboratory Billing

- All laboratory service(s) done outside of the office (laboratory, pathology, prosthetics, etc.) will not be included in the charges for OFS, LLC unless specifically noted in your Treatment Estimate. These tests, procedures and services are billed separately to either your insurance company or to you. All charges not covered by your insurance are your responsibility. You should direct any questions regarding a bill or statement from an outside laboratory to that business.
- OFS, LLC reserves the right to send all necessary lab specimens to the lab of its choosing.

Guarantor

- Any patient over the age of 19, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.
- Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card and guarantor's valid identification at each visit if a claim is to be filed.
- The accompanying parent or adult is responsible for payment in full at the time of service. In case of divorce, it is the parents responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

Fees

- A 1.5% service charge (18% annually) is added to any balance over 60 days old.
- 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.
- Please be aware that in case of a returned check, a $30 charge will be collected in order to cover the cost incurred from our bank and your account will be placed on a "cash-only basis." We will accept payments only be cash or credit card until the balance is cleared.
- There is an administrative fee of $15 for completing forms and must be paid in advance.
- Pursuant to Alabama Law Section 12-21-6.1, to copy medical records per patient request or for participation in a Deposition or Phone Consultation on your behalf, you will be charged a $5 processing fee plus $1 per page up to 25 pages, $0.50 per page for 25+ pages and actual cost of mailing the record if necesary. Radiology fee for a CD of x-rays and /or CT scans is an additional $2 fee.

Collections

- Failure to settle your account balance within 90 days of service, will result in your account moving into a collections status.
- Past due accounts may hinder your ability to have appointments scheduled and may result in your dismissal from the practice.

Statement of Financial Responsibility

I, the undersigned, have read the above and understand that I am responsible for all medical, dental and surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by OFS, LLC. I understand that my medical/dental insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to OFS, LLC. I understand that a verification of benefits and estimate of treatment are provided in good faith and are only estimates. I am ultimately responsible for all fees related to my provided service. All court and attorney fees or other fees associated with the collection of my account are my financial responsibility.

Patient Name (Printed) | Patient Signature or Parent/Guardian Signature (if patient is a minor) | Date

If patient is over the age of 19 and a Guarantor has been listed on Patient Intake Form, Guarantor must also sign below

Guarantor Name (Printed) | Guarantor Signature | Relationship to Patient | Date

Notice of Privacy Practices Acknowledgment
Authorization for Marketing Communications

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize OFS, LLC (OFS) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that OFS has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Printed)	Patient Signature (parent/guardian if minor)	Relationship to patient	Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date _____ Reason _____ Staff _____

Personal Representative Designation

Federal law states that OFS cannot share your health information without your permission except in certain situations. If you sign this form, you are giving OFS permission to treat the person(s) you name as your Personal Representative, and to share your health information with that person. You can name more than one person as your Personal Representative. This Personal Representative Designation will remain in effect until the Revocation section is signed and submitted to OFS. Revocations or changes to this designation will not apply to information that has already been released by OFS. I understand this designation is voluntary and is being made at my request. I name the following person(s) to act as my Personal Representative:

Name	DOB	Relationship to patient	Name	DOB	Relationship to patient

☐ This person(s) has all the rights that I have regarding my health information maintained by OFS.

☐ This person(s) is acting as my Personal Representative only for these functions: _____

Patient Signature (parent/guardian if minor) _____ Date _____

REVOCATION: I no longer want the person(s) named above to act as my Personal Representative.

Patient Signature (parent/guardian if minor) _____ Date _____

OFS values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. The law allows us to send written communications to you about treatment and health care operations, including products and services we offer. This is a normal part of our provider-patient relationship, and no permission is required for us to do so. We believe such communications are a valuable part of our relationship with you. However, certain types of communications cannot be sent to you unless you provide written authorization to receive them such as information regarding additional services or products that we offer in our office.

☐ I agree to allow OFS to use my name, mailing address, phone numbers and/or email address for the purpose of contacting me or sending me materials for internal marketing. My information will not be shared with a Third Party unless additional consent is obtained.

Patient Signature (parent/guardian if minor)	Date

Consent for Photography/Videography

I have been advised that photographs and/or videos will be taken of me or parts of my body before and after surgery. The photographs and/or videos will be taken by one of the members of the OFS, LLC medical staff.

I have been provided the opportunity to ask questions concerning medical photography/videography and understand that refusal to consent will not affect my medical care.

I will not be identified by name in any of the media described; however, I also understand that in some circumstances the photographs, slides, or video may display features that identify me. My consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party without my express written permission.

I release and discharge OFS, LLC, any employees of OFS, LLC and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to such use and publication, and all rights, if any, that I may have in such photographs/videos and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication.

I hereby give my consent for OFS, LLC to use the photographs/video under one or more of the following circumstances: (Initial all that apply)

_____ Medical Record: The use of my medical images for medical records includes recording and saving images in the print or digital record for office use. My images will be kept confidential within my personal medical history file at OFS, LLC.

_____ Consultation Services: The use of my medical images for consultation purposes includes sharing of these images with other healthcare providers who are involved in the diagnosis and treatment of my conditions.

_____ Education: The use of my medical images for teaching purposes includes the use of my images for teaching medical students, medical residents, practicing physicians and other healthcare professionals. This includes, but is not limited to publications and presentations both in print and in electronic format.

_____ Marketing: The use of my medical images for the marketing purposes includes the use of my images in print, electronic, or broadcast media, including, but not necessarily limited to newspapers, pamphlets, educational films, internet, and television

I have the right to revoke this authorization at any time. Revocation must be provided in writing and should be presented to OFS, LLC at 747 North Dean Road, Auburn, Alabama 36830. Revocation will take effect 60 days after being received and shall not affect any release of information made prior to revocation in reliance upon this Authorization.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will supersede any other photography/videography consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

If patient is unable to consent on his/her own behalf, then a parent/guardian must sign below

_____ _____
Parent/Guardian Signature Relationship to Patient

_____ _____
Witness Signature Date

Smoking Risk Consent Form

Patient Name _____ Date of Birth _____ Age _____

Please indicate your current status by initialing next to the correct statement below

_____ I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

_____ I have smoked and stopped approximately _____ months (or) _____ years ago.

Any medical or dental surgical procedure carries an element of risk for complications and or failure. Risk factors can vary greatly from patient to patient. Smoking has been documented in the literature to delay wound healing and therefore increase the risks of complications and failure. I am aware that use of tobacco / nicotine products may increase my risk of failure and post-operative complications including but not limited to pain, swelling, infection and potential loss of implants. I acknowledge and fully understand I will be responsible for any added expenses for revisions or prolonged post-operative care.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date