PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Home Phone_____ Wireless Phone_____ Work Phone_____

Address_____

Address 2_____

City_____ State_____Zip_____

Email_____

Preferred contact method ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email

Referral Information

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

INSURANCE POLICY 1

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name_____Subscriber ID # _____

Subscriber Date of Birth_____ Group #_____

Insurance Company _____Phone_____

Address_____

City_____ State_____ Zip_____

Employer_____Group Name_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name_____Subscriber ID # _____

Subscriber Date of Birth_____ Group #_____

Insurance Company _____Phone_____

Address_____

City_____ State_____ Zip_____

Employer_____Group Name_____

Comments:

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD (Please underline which applies):**
   - A. Rheumatic Fever or Rheumatic Heart Disease? Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .. Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ..... Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

     _____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

     _____

     _____
9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Do you wish to talk to the doctor privately about anything? ..... Y N
15. Have you ever had a bone density scan? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date | Signature of Person Completing Health History | Doctor's Initials

FINANCIAL/OFFICE POLICY FOR IDENTITY ORAL SURGERY

We are committed to providing you with the best possible care. Our professional fees can be discussed with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our financial policy, fees or what your responsibility is. **All patients must complete and understand this form before seeing the doctor.**

- *Full payment (or co-payment) is due at the time of the visit. We accept cash, check, Visa, Mastercard, Discover, AMEX.*
- *Balances over 90 days are subject to an outside collection effort, and Identity Oral Surgery is entitled to recover, to the extent permitted by applicable law, collection costs, including a collection fee charged by the third party collection agency in the amount of 35% of the patient's outstanding principal obligation, interest, court costs and reasonable attorney's fee, etc. allowed by Utah Code.*
- *Returned checks will be assessed a $25.00 returned check fee.*

Insurance Policy

If you have insurance, we will assist you to receive the maximum benefits. We spend time speaking with your insurance company to determine what your benefits are so that we can provide you with a best estimate of what your responsible portion or co-payment will be for your oral surgery services. However, **this is only an estimate.**
After any services have been completed it is possible that your insurance company may pay as we estimated, they may pay more than we estimated, or they may even pay less than we estimated. If they pay more than we estimated and your account accrues a credit, we will refund the credit within 60 days. If your insurance company pays less than was estimated your account will have a remaining balance due. ***The balance is your responsibility whether your insurance company pays or not.*** Pre-estimate of benefits is never a guarantee of payment by your insurance company. At the time of your appointment, please let us know of any insurance changes you may have had recently.

Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract. In the event we do not accept assignment of benefits, we require payment in full by the patient. If your insurance company has not paid your account in full within 45 days, the balance will be the responsibility of the patient. Some or perhaps all of the services provided may be "non-covered" or are not considered "reasonable and customary" under your dental plan. These services are then the responsibility of the patient. You are also responsible to know what your maximum benefit is and how much you have remaining at the time of your visit. Due to privacy policies we are unable to track your benefits and cannot find out if benefits have been used elsewhere, therefore we are not responsible for any unpaid claims.

If you have a dispute over a balance because your insurance company did not pay in accordance with any kind of pre-authorization, please understand that this dispute is not with our office but is with your insurance company. This balance is due in full within 30 days of your first billed statement. We will continue any proceedings needed to collect this balance and are entitled to recover collection costs.

No Insurance Policy

Adult patients or the parent/guardian accompanying a minor are required to pay the full amount at the time of service. For unaccompanied minors, non emergency treatment will be denied unless charges have been pre-authorized. We do not have an in office payment plan, but can help you find financing if needed. Please ask us.

I authorize that I have read the entire financial policy and I understand and agree with it.

Printed Name:_____**Signature:**_____**Date:**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, hereby acknowledge that I have received or have been offered a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Patient did not want a copy of our Privacy Notice

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)