Welcome to San Gabriel Oral & Maxillofacial Surgery Associates

PATIENT INFORMATION (CONFIDENTIAL)

Please complete the following forms to the best of your abilities. (PLEASE PRINT)

Patient's Name _____

Day of Birth _____ Soc. Sec. # _____

Male Female Minor Single Married Divorced Widowed Separated

Home Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Spouse's Name _____ Employer _____ Work # _____

Emergency Contact Person: _____ Phone: _____

Whom May We Thank for referring you _____

If the patient is not responsible for payment of this account please complete the following information:

RESPONSIBLE PARTY

Responsible Person's Name _____

Home Address _____

Relationship to Patient _____ Soc. Sec. # _____ DOB _____

Home Phone _____ Work Phone _____ Alternative Phone _____

Employer _____ Address _____

INSURANCE INFORMATION

Policy Holder's Name _____ S.S.# _____ DOB _____

Employer _____ Address _____ Work# _____

Insurance Company _____ Phone _____

Insurance Company Address _____

Policy ID # _____ Group # _____

X _____ _____

Signature of Patient or Parent/Guardian if Minor Date

PATIENT MEDICAL HISTORY

Patient Name _____ DOB _____ Date _____

Although Oral Surgery primarily treats the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the treatment that you will be receiving. Thank you for answering the following questions.

Are you in good health?	Y	N	Have you ever required a blood transfusion	Y	N
Have there been any changes in your general health within the past year?	Y	N	Have you had a recent weight loss	Y	N
			Do you use Tobacco	Y	N
Date of your last physical exam: _____			Do you or have you used controlled substances	Y	N
Physician's Name: _____			Are you wearing contact lenses?	Y	N
Address: _____			Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	Y	N
Phone Number: _____					
Are you now under the care of a physician	Y	N	Have you ever had a serious injury to your head or neck?	Y	N
Have you ever been hospitalized for any surgical operation or serious illness	Y	N	Are you on any special diet?	Y	N
Please explain: _____			Have you or are you currently having Chemotherapy or Radiation therapy?	Y	N
Are you taking any medications	Y	N	Are you pregnant or think you may be pregnant	Y	N
If yes, what medications are you taking: _____			Are you nursing?	Y	N
Have you had any abnormal bleeding?	Y	N	Are you taking birth control pills?	Y	N
Do you bruise easy	Y	N			

Are you allergic to or have you had reactions to:

Aspirin_____ Penicillin_____ Codeine_____ Novocaine_____ Metal_____ Latex Rubber_____
Local Anesthetics_____ Iodine_____ Sulfa drugs_____ Barbiturates or sleeping pills_____

Do you now have or have you ever had any of the following? Please check if appropriate.

☐ Heart Murmur	☐ Stroke	☐ Hemophilia	☐ Tumors/Growth	☐ Liver Disease	☐ Venereal Disease
☐ Pacemaker	☐ Leukemia	☐ Emphysema	☐ Hepatitis A, B or C	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Heart Surgery	☐ Cancer	☐ Kidney Disease	☐ Stomach Ulcer	☐ Lung Disease	☐ Low Blood Pressure
☐ Heart Trouble	☐ Blood Disease	☐ Thyroid Problems	☐ Breathing Problems	☐ Immune Deficiencies	☐ TMJ
☐ Artificial Heart Valve	☐ Artificial Joint	☐ Anemia	☐ Asthma	☐ Diabetes	☐ HIV Positive
☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Epilepsy/Seizure	☐ Psychiatric Care	☐ Tuberculosis	☐ Sinus Trouble

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I will inform the Doctor and staff at the next appointment without fail. I will not hold my Doctor, or any staff members responsible for any errors or omissions that I may have made in the completion of this form

X _____ Date _____
(Patient signature / Parent or Guardian signature)

Reviewed by Doctor _____ Date _____ BP _____
History Reviewed and Significant Findings _____

FINANCIAL POLICY

Our mission is to deliver the finest most cost effective Dental/Medical Care available. Following diagnosis, the doctor will advise you on a plan for treatment. Additionally, we will discuss with you the cost of today's and any future treatment.

Payment for today's visit and any future visits are due at time of treatment. In an effort to make oral surgery more affordable for you, we participate in three basic types of dental and medical benefit programs.

- **DMO/HMO** programs entitle the participants to reduce fees or co-pays and require payment at the time services are provided. These programs generally do not pay for specifics services provided to you. Your benefits are in the substantially reduced fees offered under the plan.

- **Indemnity Dental Insurance** allows for your reimbursement of a percentage of the fees for treatment services. Your insurance policy is a contract between you and your insurance company. When we accept your insurance company's assignment, it does not absolve you from full responsibility for your charges in full for the treatment rendered. The estimate provided by our office is considered as a guideline until final insurance payment, if any, is received and the patient's account has been paid in full. We make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimate portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the 60th day after treatment is rendered, the total outstanding account balance will be billed directly to the patient. Our Team prides itself on helping our patients maximize their benefits. We are always available to answer any questions you may have regarding your treatment. **Predetermination**-Another way of determining your exact liability is to have our office file a Predetermination of benefits. Predetermination may take up to six weeks, thereby delaying the start of your treatment.

- **PPO (Preferred Provider Organization)** type programs are preferred providers or referral programs which entitle the participant to reduced fees according to their plan fee schedules and usually a discount on services not covered by the plan. These plans generally have a percentage of the fees that are paid by the patient at the time treatment is rendered. Some plans require a claim form for submission once services have been provided.

The existence of a dental procedure code does not mean that a procedure is a covered or reimbursed benefit in a dental benefit plan. It is not easy for an office to become familiar with the details of every dental plan it encounters. And it is, of course, the responsibility of the patient, not the dental office, to know what is covered and what is excluded from her or his dental plan. Certain dental benefits plans require predetermination for specific procedures or when covered charges are expected to exceed a certain amount.

There will be additional charges for any duplication of patient's records that may be requested.

Payment Options

- Cash – includes money order and personal checks.
- Credit Card – to include Visa, Master Card, American Express, and Discover.
- Care Credit – offer a separate line of credit to cover your entire family's health care needs.

    1. Applicant may fill out an application in our office with a response, less than 20 minutes.
    2. Treatment total must be no less than $300.

It is Your Responsibility to pay for services at the time you receive them, regardless of any dental plan or insurance benefits you may have. We will provide monthly statements on accounts that have a balance. Unpaid account balances greater than 60 days will be charged a one time fee of 30% of the remaining balance.

By signing below, I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefits be paid to San Gabriel Oral & Maxillofacial Surgery Associates, P.A. I also authorize the doctor to release to my insurance carrier(s), any information required to process any claim(s).

Patient's Name: _____

Signature of Responsible Party: _____ Date: _____

HIPPA PRIVACY
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy policy (the "Policy") of **San Gabriel Oral & Maxillofacial Surgery Associates, P.A.**, and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____ [Please initial here] **I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.**

_____

Signature of Patient/Parent Date

For Office Use Only

I,_____ [Please print full legal name here], acting as

_____ [Please print relationship to or official position with Provider] for Provider attempted to obtain written acknowledgement of receipt of the Policy of Provider on _____ [Please insert date attempt was made], but acknowledgement could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency Circumstances prevented securing acknowledgement.

_____ [Please initial here] Other (Please specify) _____

_____

_____

_____

_____

Signature of Provider Representative Date