Patient Registration Form

Oral & Maxillofacial Surgery

Thank you for taking your time to complete these forms. All of this information is important for the doctor and his staff to provide you with the highest level of care and service. If you require any assistance, please notify the receptionist.

Patient's Name____Date______________

Address ____

City ______________________State ___________________Zip Code______________________

Home Phone _______________________Work Phone____________Cell Phone______________________

Social Security #_______________________Age_________Birth date ____________Marital Status_________

Name of Spouse/Significant Other _______________________Name of Parent (if patient is a minor) ____________

Name & Relationship of Contact Person not living with You____

Address____Phone__________________________

Employer' Name____Occupation_______________

Employer's Address____Employer's Phone______________

Person Responsible for Account: ________________________Relationship to Patient___________________

If different than above: Responsible Person's Address__________________________________Phone______________

Social Security Number____Date of Birth__________________

If patient is a college student: College ____________________Dates of Attendance ________Date of Graduation___________

Dentist's Name___________________________________Physician's Name_____________________________

Address_______________________________________Address_______________________________________

City ___________________________State____________City _______________________State____________

Phone ________________________Last Visit___________Phone _______________Last Visit_____________

Whom may we thank for recommending you to our office____

Present Problem/Reason for Visit____

How long has it been a problem_______(hours/days/weeks)? Have you sought care elsewhere? _____________

If you are in pain, does anything worsen or improve it? ____

All information is strictly confidential.

Patient'sName____Date_____________

Height: ___________ Weight: ____________

Please take a few moments to complete this health survey. Please read each item listed, and circle it if you have, think you have, or ever have had the condition listed.

Allergies, allergic reactions, rashes, skin blotches, swollen tongue, breathing trouble, as a result of penicillin, ampicillin, amoxicillin, latex rubber or gloves, metals, any drug or medicine, problems with anesthesia, hives

Heart murmur, mitral valve prolapse, rheumatic fever, rheumatic heart disease, heart surgery, chest surgery, endocarditis, heart infection, born with a heart problem, congenital heart problem, taken an antibiotic to protect your heart from an infection, irregular heart beat, artificial heart valve

Cardiovascular disease, heart disease, heart trouble, coronary artery disease, atherosclerotic heart disease, hardening of the arteries, heart attack, heart bypass surgery, angioplasty, high blood pressure, hypertension, stroke, palpitations, fainting spells, vein surgery, vascular disease, placement of a pacemaker, neck surgery, carotid artery surgery, angina

Lung disease, lung surgery, asthma, COPD, emphysema, reactive airways, chronic cough, chest pain, pneumonia, bronchitis, shortness of breath, tuberculosis, the need to be intubated, or any problem breathing

Liver disease, cirrhosis, hepatitis, yellow skin, jaundice, kidney disease, nephritis, problems or blood with urination, Gastrointestinal problems, ulcers, colitis, bloody or tarry stools, diarrhea, recent weight changes, dialysis

Bleeding problems, bleeding tendencies, hemophilia, sickle cell disease, anemia, problems with easy or unexplained bruising, blood transfusions, any blood disease, leukemia

Seizures, convulsions, epilepsy, a shunt, concussion, skull fracture, dizziness, vertigo, psychiatric treatment, mental health therapy, nervous disorder, a breakdown, rehabilitation therapy, drug or alcohol rehabilitation

Endocrine problems, diabetes, sugar problems, thyroid disease, adrenal disease, Grave's disease, parathyroid disease, frequent thirst or frequent urination

Cerebral palsy, multiple sclerosis, muscular disease, bone disease, skeletal disease, developmental disability, mental retardation, hyperactivity, attention deficit disorder, emotional disorders, psychiatric care

Transplant operation, organ replacement, drugs to suppress your immune system, steroid therapy, immune disease, immune compromise, HIV infection, AIDS, taken prednisone, taken cortisone

Implant surgery, implants placed in your body, heart valves replaced, knee replacement, hip replacement, cosmetic surgery, abdominal surgery, gall bladder surgery, appendix removal, orthopedic surgery, bone or spine surgery

Tumor, cancer, chemotherapy, cancer therapy, radiation therapy, hyperbaric oxygen therapy, radiation seeds, growths

Jaw pain, arthritis, clicking or popping of jaw joint, headaches, jaw 'stuck' open or closed, mouth appliance, jaw surgery, TMJ, temporomandibular joint problems, neuralgia, migraines, whiplash injury, car accidents or other trauma

WOMEN: pregnant, planning pregnancy, breast feeding, using birth control pills or implant, hormone replacement therapy

☐ NONE OF THE ABOVE

Patient's Name____Date____________________

Are you in good health? ____________If not, why_______________________________________

Has there been any change in your health in the last year?________________________________

Are you under the care of a physician for any particular problem? __________________________

When and why was your last visit to the doctor?____

Do you use tobacco? ____________Did you ever? _____________How much, how often? ______

Do you drink alcohol?_____________How often?________________How much?______________

Do you use illicit drugs?__________What kinds?________________How often?______________

Do you have, or have you ever experienced pain in your jaw, clicking or popping in your jaw joint, a jaw that was stuck open or closed, shooting pain towards your ear, or along the side of your head? If yes, please explain:

____

Allergies: Please list any drug, medication, food or latex allergies and the reaction:

____

Medications: Please list any medication you are, or have ever, regularly taken, or been prescribed:

____

Supplements: Please list any herbs, vitamins, supplements or diet variations

____

Hospitalizations/Surgeries/Operations/Illnesses: Please list any and when

____

Exercise: Please describe your routine exercise regimen

____

Do you have, or have you ever had any disease, condition, or problem not listed here that you think the doctor should know about, or do you wish to talk to the doctor privately about anything?

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Do you wear contact lenses, hearing aids, or have any special needs for a physical disability?

I understand the importance of providing a complete and truthful history, to assist the doctor in providing the best care possible. I have had the opportunity to discuss my health history with the doctor, and the information I have provided here is complete and accurate. I also consent to examination, radiographs (x-rays), medications, diagnostic or therapeutic procedures as may be indicated for proper care. I understand that I personally have full financial responsibility for the care that I receive.

Patient/Guardian Signature__________________________________ **Date**____________

Patient's Name____Date________________

Payment for consultation and x-rays is expected the day the services are performed.

This authorization is in effect for the entire course of treatment your receive with our office

Our office strives to offer the highest level of service, and strives to foster a positive patient-doctor relationship. We would like to take a few moments to clarify our financial policy. Our office does not participate in, or accept assignment from any insurance programs, or third party payers. You agree to pay all fees in full associated with the treatment received and also to submit all claims to third party payers yourself. If your treatment includes a surgical procedure, you may also be given the Financial Policy for Surgical Procedures.

I understand that any information concerning insurance coverage or third party payments is not guaranteed, and my actual insurance benefits may be more or less than any estimates. Insurance is a contract between an insurance company and an individual. I understand, that even if a third party claims that this office participates in a third party payment plan or insurance plan, or makes claims regarding fees, approved charges, or other language, I fully understand that I personally have full responsibility for the charges. I am opting out of any third party payment for the treatment I receive from this office, and I hold the office and doctors harmless for any claims to the contrary. Any questions or disputes concerning that contract should be undertaken with that insurance company. The fees payable to our office are due in full, regardless of any payments made to you, by any and all third parties.

I understand that any installment payment plan is actually an extension of credit, and therefore authorize any necessary credit reports. I hereby authorize the release of my records and any other information to third party payers, other health professionals, dental organizations, electronic clearinghouses, state and federal agencies, courts and academic organizations. I also authorize other medical professionals to release their records to this Oral Surgery Office, to aid in the delivery of care. I also consent to photography and videotaping for educational marketing, and training purposes.

I understand that if I have a payment plan, and I do not, make my payments by the due date, and/or pay the entire balance on my account within sixty days, a service charge may be added to the account. The addition of the service charge may or may not appear on the next statement. This service charge will be ten dollars for any month in which there is an unpaid balance. If a payment schedule has been arranged, there will be a $40 dollar late fee charged to the account, for payments not received by the first of the month, in which a payment is due (This will be additional to the $10.00 monthly account service charge). In the case of default of payment, I promise to pay any/all legal interest on the balance due (at an APR of 18%), together with any/all collection costs, and legal fees incurred to effect collection of this account. If a judgment is entered against me, the amount will include interest and costs of the suit, release of errors, without stay of execution, and fifty percent (50%) as a reasonable attorney's fee. I also waive and release all benefit and relief from any and all appraisement, stay, or exemption laws of any state, now in force, or hereafter to be passed. Checks returned as unpayable will incur a $50 service charge. If check payments remain uncollected, criminal/civil prosecution may occur. If there is any dispute related to the care received, or financial obligations related to it, I agree to utilize the peer review system available through the New Jersey Dental Association, as administered through the Department of Dental Care programs at 732-821-9400. If your account is in default, any discounts or courtesies that were applied to the fees for service will be removed.

The Doctors and staff have attempted to estimate the total costs for surgery. On occasion actual treatment requirements may change and involve additional and unforeseen expenses. These may include additional current treatment; additional treatment in the future; outside treatment and fees associated with obtaining further treatment, including, but not limited to travel, housing, meals, consultations, surgery, anesthesia, biopsy reports, pathology fees, CAT Scan, MRI fees, hospital fees, or medication costs.

Medicare Release: I understand that Medicare may determine that there are no benefits payable for procedures performed. If this occurs, I understand I will be responsible for the costs of treatment. Medicare does not cover any dental treatment, or any surgery that facilitates dentistry, the removal or replacement of teeth.

I have reviewed and approve the treatment, treatment estimate, payment agreement, terms and conditions. I understand that there are no guarantees associated with my care. Any additional services, treatment, or postoperative care required, either the day of initial surgery, or in the future, may incur additional fees. This authorization applies to all services provided. Payment plans and arrangements are available, and can be discussed with the staff at anytime. The total fee for service is payable regardless of the frequency of the billing cycle.

Signature____Date________________

In accordance with confidentially laws, I give the doctor, his office and his staff permission to discuss my personal medical information (PMI) with the following people:

1. **Medical Doctor # 1:** ______________________________
2. **Medical Doctor # 2:** ______________________________
3. **Dentist # 1:** ______________________________
4. **Dentist # 2:** ______________________________
5. **Family Member/Friend:** ______________________________
6. **Family Member/Friend:** ______________________________
7. **Family Member/Friend:** ______________________________

Pharmacy name, address, and telephone number:

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Patient's E-Mail address: ______________________________

Family Member E-mail Address (If Applicable)**:** ______________________________

Please provide our office with your insurance information, both medical and dental, to best serve you. Please be advised that we do not participate with insurance plans. However, we are very happy to submit claims on your behalf for you to be reimbursed. If you have several insurance plans, please provide all of the information to us.

Medical Insurance Name: ______________________________ Ins. Telephone No. ____________

ID No. ____________________ Group No.____________ Plan type: Traditional PPO POS HMO

Referral needed? Yes or No Prior authorization needed? Yes or no Deductible amount ____________

Dental Insurance: ______________________________ Ins. Telephone No. ____________

I D No. ________________ Group No. ____________ Plan type Traditional PPO HMO Discount plan

Referral needed? Yes or N Prior authorization needed? Yes or no Deductible **$**________________

Yearly Maximum **$**____________ Dollar amount remaining **$**____________

Skin Care Questionnaire

1. Is there anything that you would like to improve about your skin or facial appearance?
   ____
   ____

2. Are you bothered by acne, whiteheads, blackheads, or deep or blind pimples?
   ____

3. Do you have any facial scarring, rashes, or enlarged pores that concern you?
   ____

4. Do you have blotchy skin, dark spots, age spots, uneven complexion, or prominent freckles?
   ____

5. Are there fine lines, wrinkles, laugh lines, crow's feet, or sagging skin that is bothersome to you? ____

6. Please feel free to discuss these concerns with the doctor, and add any other items that the doctor should know about. ____
   ____
   ____
   ____
   ____

**** The next 2 pages are Signature Pages Only: The accompanying laminated sheets supply the details of what your signing here*****

****Carefully read the accompanying sheets because those sheets describe what your (8) signatures here represent****

Privacy Practices Acknowledgement (HIPPA) (laminated page on clipboard, under health history)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. In Accordance with confidentiality laws, I give the doctors and staff of Lincroft Oral Surgery permission to discuss my personal medical information with the following people:

Medical doctor/Physicians Dentists Hospitals Wife/Husband Children

Please cross out anyone above who you don't want us to discuss your condition with or write in special situations here:……………………..

1. ***Signature*______________________________ Name «Patient_FullName» Birthdate ____________ Date______________

Insurance Assignment and Release, and Promise of Payment and Financial Responsibility:

I certify that I. and/or my dependent(s), have insurance coverage and assign directly to Lincroft Oral Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. If your account is not paid in full on the day services are provided, I authorize recurring charges to my checking or credit card accounts to satisfy my financial obligation for the medical and dental services provided. The practice may use my health care information and may disclose such information to third parties and insurers and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. Insurance coverage does not eliminate your financial responsibility.

2. ***Signature*______________________________ Name «Patient_FullName» Relationship to Patient________________________ Date________

Commercial Insurance / Government Programs / Medicaid / NJ Family Care / Medicare/ CSOCI Payments:

Authorization to Release Information and Payment Request: I certify that the service(s) covered by this claim has/have been received and request that payment for the service(s) be made on my behalf. I authorize any holder of medical other information about me to release to any Federal, State or local agency to its authorized agents any information needed for this related claim; or for public health concerns.

Patient or Authorized Representatives Signature	Date of Service
3. «Patient_FullName»	

Patient Insurance Information Notice (laminated page on clipboard, under health history)

I have received the Notice regarding Insurance and I have had an opportunity to review it. I agree to and accept the terms as described

4. ***Signature*____ Name «Patient_FullName» Date_________________

Consent to Undergo Examination, Treatment, Surgery

Planned Procedures: Evaluation, Management, Radiographs, followed by Possible Extractions, Possible Biopsies, Possible Implants, Possible removal of tissue and bone, draining infections, treatment of trauma, advanced life saving measures, and any other indicated medical and surgical procedures.

Procedures____

I have read the attached consent form and discussed the risks that may occur. I believe I have been given, and fully understand, sufficient information to give my consent to the above surgery. I have considered, or tried, possible alternatives including no treatment. I authorize the doctors, their associates or assistants, to provide additional services as they may deem reasonable and necessary including: administering medications, laboratory, diagnostic and surgical procedures, and any care deemed advisable. If additional care is required, additional fees may also be incurred. I give my free and voluntary consent for treatment. I give consent for the Doctors to provide any medical care during the surgical procedure, even if unplanned, to attain the best outcome for the procedure. I also understand if I do not receive care, consequences include, but are not limited to, worsening of my condition. No guarantees, assurance, or results of any kind have been made.

5. ____ Name «Patient_FullName» Date________________

 Thank you and we look forward to participating in your health care and wellness

Consent for Anesthesia

I have read the attached consent form and discussed the risks that may occur. I believe I have been given, and fully understand, sufficient information to give my consent for anesthesia. I understand the type and level of anesthesia provided is at the sole discretion of the doctor, to maintain my safety and health. I understand that no guaranteed results have been offered or promised.

6. Signature_______________________________________ Name__«Patient_FullName» Date____________

Information Regarding Biopsies

In an effort to maintain the highest quality of care for all our patients, we would like to explain our office policy regarding biopsies. The condition, for which you have been referred, and are undergoing treatment, may include the removal of diseased bodily tissues. This diseased tissue is usually removed, and forwarded to a Pathologist. A Pathologist is a doctor who specializes in evaluating and diagnosing disease through laboratory analysis. Specimens may also be forwarded for other types of lab analysis. The Pathologist usually analyzes the diseased tissues that were removed as part of your treatment, by specially treating these tissues, and studying them under a microscope. The medical term to describe this process is known as histopathologic analysis. This biopsy procedure is usually performed to provide correlation with the clinical impression derived by your surgeon. There is no cause for alarm because your surgeon decided to biopsy the diseased tissues removed during your surgery. It was done to provide confirmation of his clinical diagnosis. If the biopsy diagnosis is not consistent with the clinical diagnosis, the office will contact you to discuss the discrepancy. Please be advised that the services of the pathologist are separate from that of your surgeon. As such, you may receive a separate bill for those services.

7.Signature___________________________________Name: «Patient_FullName» Date: «Today's_Date»

Consent for Procedures for Patients who have received Bisphosponate Drugs

I have read the attached consent form and discussed the risks that may occur. I believe I have been given, and fully understand, sufficient information to give my consent. I understand that no guaranteed results have been offered or promised.

8. Signature_______________________________________ Name__«Patient_FullName» Date____________