ORAL SURGERY ASSOCIATES, P.A

PATIENT INFORMATION FILE (Please Print)

Patient's Name:_____ Age:____ Birthdate:_____ Phone:_____

Street Address: _____ City:_____ State:_____ Zip:_____

Employed By:_____ Employer's Address:_____ Current Occupation:_____

City:_____ State:_____ Zip:_____ Phone:_____

Drivers License No.:_____ Social Security No.:_____

Parent or Spouse:_____ Phone:_____

Employed By:_____ Employer's Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

HEALTH INSURANCE

Dental Ins. Co.:_____ Policy No.:_____

Medical Ins. Co.:_____ Policy No.:_____

PERSON RESPONSIBLE FOR FEE: Patient:_____ Parent:_____ Spouse:_____ Other: (Name)_____

INSURANCE COVERAGE FOR YOUR TREATMENT

This office is happy to cooperate with individuals who are covered by insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. Insurance is a contract between the patient and the insurance company for benefits. It is not a contract between our office and your insurance company.

The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Some insurance companies will pay a percentage of the surgical fee, for example 40%, 80%, or 90%. Some will have you pay a deductible of $50 or $100 and then pay a percentage of your remaining bill. Some have a table of allowances and pay only a certain amount of your bill, but not all of it. Also, some companies pay claims promptly and others delay payment many months.

Since we have no control in the selection of your insurance company (nor do we feel we should), we have no control over what they will pay or when they will pay for the services provided. Therefore, we ask that you look upon your insurance realistically as a device which helps you pay for your surgical care. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is the patient's. Insurance claims not paid by the insurance companies within thirty days will be considered the responsibility of the patient. Please be assured that this office will always be happy to assist you.

FEES IN OUR OFFICE

I hereby authorize Drs. Epstein, Eisen and/or Keegan to furnish my insurance company all information which said company may request concerning my present illness or injury. I hereby assign to Drs. Epstein, Eisen and/or Keegan all sums payable to me from the amount of money to which I am entitled for medical and/or surgical expenses. I understand that I am financially responsible for those charges not paid by my insurance. I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

The fee for your treatment is determined by the complexity of your case. It is our policy that all fees are to be paid on the day of surgery. Any fee or portion of fee unpaid 60 days after completion of surgery is subject to a late fee of 1.5% per month (18% per annum). Should collection action be required to secure payment, you will be charged a reasonable attorney's fee of 30% of any amount outstanding as well as being charged for any court fees and interest.

I have read the above statements and understand them.

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

_____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

_____

SIGNED (INSURED PERSON) DATE

Medical and Health History Questionnaire

Who referred you to this office?_____

The name and phone number of my physician is_____

The name and phone number of my dentist is_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Have you ever:

Had a serious illness	Yes	No
Been hospitalized in the last 5 years	Yes	No
Had a surgery or an operation in the past	Yes	No
Been under a doctor's care in the last 6 months	Yes	No
Had excessive bleeding after a surgery	Yes	No
Had a blood transfusion If so when_____	Yes	No
Had periods of unconsciousness or fainting spells	Yes	No
Had a problem with local or general anesthesia	Yes	No
Been immunosuppressed or have problems of the immune system	Yes	No
Been treated for an alcohol or a drug usage problem	Yes	No
Taken medication to prevent Osteoporosis	Yes	No

MEDICATIONS:

Please list medications, prescriptions, non-prescriptions or herbal:_____

_____

_____

ALLERGIES:

Are you allergic to any medicines, food, or latex_____

_____

_____

Do you currently smoke or chew tobacco products	Yes	No
Did you smoke or chew tobacco products in the past	Yes	No

All Patients This Section

Do you have any other dental/medical problems, or diseases that were not listed that we should know about	Yes	No
Do you wish to discuss anything in private with the doctor	Yes	No
Are you planning to be sedated (nitrous oxide, I.V. sedation) or go to sleep (general anesthesia)	Yes	No
Did you come with someone responsible who can take you home	Yes	No

When was the last time you had anything to eat or drink_____

_____

Do you have or have you ever had any of the following:

Heart, cardiovascular disease, angina or chest pain	Yes	No
Congenital heart defect	Yes	No
Heart murmur	Yes	No
Rheumatic fever or rheumatic heart disease	Yes	No
Stroke or Transient ischemic attacks (TIA's)	Yes	No
Blood pressure problems	Yes	No
Kidney disease	Yes	No
Lung disease, shortness of breath or emphysema	Yes	No
Tuberculosis	Yes	No
Asthma	Yes	No
Sinus or nasal problems	Yes	No
Hay fever	Yes	No
Hepatitis/jaundice or liver disease	Yes	No
Stomach ulcers, gastritis, acid reflux, or hyperacidity	Yes	No
Colitis, diverticulitis or Crohn's disease	Yes	No
Diabetes	Yes	No
TMJ problems (pain near the ear, clicking or popping of the jaw joint, difficulty opening the mouth)	Yes	No
A blood disorder (i.e. white or red blood cell, or platelet problems)	Yes	No
Bleeding or clotting problems	Yes	No
Anemia or sickle cell anemia	Yes	No
Seizure disorders/epilepsy/convulsions	Yes	No
Thyroid disease or problems	Yes	No
Cancer	Yes	No
Radiation therapy or x-ray treatments for cancer	Yes	No
Glaucoma	Yes	No
Cortisone or steroid therapy	Yes	No
Arthritis	Yes	No
Implants, transplants, or synthetic grafts placed anywhere in the body	Yes	No
Hip, knee or heart valve replacements	Yes	No
Mental health problems or psychiatric disorders	Yes	No
Osteoporosis	Yes	No

Female Patients Only This Section

Are you taking birth control pills	Yes	No
Are you currently nursing (breast feeding)	Yes	No
Are you, or is there a chance that you may be pregnant	Yes	No

_____

Signature of patient/or legal guardian in the case of a minor

Date_____