ALLIANCE ORAL AND MAXILLOFACIAL SURGERY

Thank you for choosing our practice for your oral surgery needs. If you have questions or concerns about content or any other information in this form, do not hesitate to ask for assistance. We will be happy to help. Thanks for your cooperation.

PATIENT INFORMATION

Patient's Name:

Birth Date: / /	Age:	Sex: ◯ M ◯ F	Marital Status: ◯ Single ◯ Married ◯ Widowed

Street Address:

City:	State:	Zip Code:

Cell Phone:	Home Phone:	Email:

What's the reason for your visit today?

General Dentist Name:	Orthodontists Name:

Preferred Pharmacy (Name, Address & Phone)

Have any of your family members been patients at this office? ◯ Yes ◯ No
Names:

RESPONSIBLE PARTY

Name of person responsible for Account:

Relationship to Patient: ◯ Self ◯ Parent ◯ Spouse ◯ Other	Social Security No.

Street Address: ◯ Same as Above	City:

State:	Zip Code:	Phone:

Employer:	Work Phone:

IN CASE OF EMERGENCY

Emergency Contact Name:

Relationship to Patient: ◯ Self ◯ Parent ◯ Spouse ◯ Other	Phone No:

HOW DID YOU HEAR ABOUT US?

◯ Referred by my doctor:
◯ Dentist ◯ Orthodontist ◯ Endodontist ◯ Pediatric Dentist ◯ Other: _____
Name:

◯ Referred by Family Member /Friend /Patient ◯ Search Engine / Website ◯ Insurance Network ◯ Other Source
Name:

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N). ALL RESPONSES ARE KEPT CONFIDENTIAL.

1 ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? Y N

2 DO YOU HAVE JAW POPPING OR PAIN? Y N

3 FAMILY HISTORY OF SEVERE REACTION TO GENERAL ANESTHESIA Y N

4 LIST ALL OPERATIONS AND HOSPITALIZATIONS:

DO YOU HAVE OR HAVE YOU HAD:

5
A. SINUS OR NASAL PROBLEMS OR ALLERGIES Y N
B. SLEEP APNEA Y N
C. STROKE, SEIZURE, EPILEPSY Y N
D. MENTAL HANDICAP, PSYCHIATRIC TREATMENT Y N
ALZHEIMER'S OR PARKINSON'S Y N
E. CONGENITAL HEART DISEASE, HEART SURGERY, CHEST PAIN, HEART ATTACK, CONGESTIVE HEART FAILURE, HEART MURMUR, VALVE DISORDER, PALPITATIONS, ARRHYTHMIA, HIGH BLOOD PRESSURE Y N
F. LUNG DISEASE: ASTHMA, COPD, Y N
BRONCHITIS, PNEUMONIA OR TUBERCULOSIS Y N
G. BLEEDING DISORDER OR TENDENCY Y N
OR ANEMIA Y N
H. LIVER DISEASE: JAUNDICE, HEPATITIS Y N
I. KIDNEY DISEASE Y N
J. DIABETES Y N
K. THYROID DISEASE Y N
L. REFLUX OR STOMACH ULCERS Y N
M. COLITIS - ULCERATIVE OR CROHN'S Y N
N. GLAUCOMA Y N
O. ARTHRITIS Y N
P. OSTEOPOROSIS Y N
Q. CANCER Y N
R. RADIATION (X-RAY) TREATMENT FOR CANCER Y N
S. IMPLANTS PLACED ANYWHERE IN YOUR BODY (HEART VALVE /JOINT REPLACEMENT) Y N
T. ANY DISEASE THAT HAS DEPRESSED YOUR IMMUNE SYSTEM OR HIV Y N
U. ANY OTHER DISEASE OR DISORDER NOT LISTED ABOVE, PLEASE LIST:

6 ARE YOU USING OR TAKING ANY OF THE FOLLOWING:
A. ANTIBIOTICS Y N
B. ANTICOAGULANTS (BLOOD THINNERS) Y N
C. HIGH BLOOD PRESSURE OR HEART MEDICINE Y N
D. STEROIDS (CORTISONE) Y N
E. INSULIN OR ORAL MEDICATION FOR DIABETES Y N
F. DRUGS FOR BONES - OSTEOPOROSIS (currently using or used in past)
Fosamax, Binosto, Actonel, Boniva, Aredia, Reclast, Prolia Y N
DRUGS FOR BONES - CANCER (CURRENTLY USING or USED IN PAST)
Zometa, Xgeva, Avastin, Sutent, Nexavar Y N
G. MARIJUANA OR OTHER "STREET DRUGS" Y N
H. LIST ALL MEDICATIONS YOU TAKE:

7 ARE YOU ALLERGIC OR HAVE YOU HAD A BAD REACTION TO:
A. GENERAL ANESTHESIA OR LOCAL ANESTHETICS Y N
B. PENICILLIN, AMOXICILLIN, CEPHALOSPORIN OR OTHER ANTIBIOTICS Y N
C. ASPIRIN OR IBUPROFEN Y N
D. CODEINE, HYDROCODONE, OR OTHER PAIN MEDICATIONS Y N
E. LATEX Y N
F. OTHER ALLERGIES OR REACTIONS - PLEASE LIST:

8 DO YOU SMOKE, CHEW, OR DIP TOBACCO Y N

9 DO YOU HAVE OR HAVE YOU HAD AN ALCOHOL OR DRUG DEPENDENCE Y N

10 FOR WOMEN ONLY:
A. If you are using oral contraceptives, it is important that you understand that antibiotics and 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 medications is completed. Please contact your physician for further assistance.
B. If you are pregnant, possibly pregnant or trying to become pregnant, anesthesia and other medications may significantly harm your developing baby, especially during the first trimester.
PLEASE ADVISE YOUR DOCTOR IF THERE IS ANY CHANCE OF YOUR BEING PREGNANT!
C. Are you pregnant? Y N
D. Are you nursing? Y N

I UNDERSTAND THE IMPORTANCE OF AN ACCURATE HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DATE DOCTOR'S INITIALS

Alliance Oral and Maxillofacial Surgery

Patient Name: _____

Please complete your insurance information below. If you are a self pay patient and no insurance will be processed for your visit, check the self pay option below and sign this document.
Thank You!

☐ **SELF PAY (No Insurance)**

☐ **DENTAL INSURANCE INFORMATION**
Primary Holder: Patient / Spouse / Parent (CIRCLE ONE)
Name of Primary Holder: _____
Birthday of Primary Holder: _____
SS# of Primary Holder: _____
Employer of Primary Holder: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

☐ **MEDICAL INSURANCE INFORMATION**
Primary Holder: Patient / Spouse / Parent (CIRCLE ONE)
Name of Primary Holder: _____
Birthday of Primary Holder: _____
SS# of Primary Holder: _____
Employer of Primary Holder: _____
Insurance Company Name: _____
Insurance Company Phone #: _____
Subscriber ID #: _____
Group #: _____

PLEASE READ THIS CAREFULLY

You are entering into a relationship with the doctor, in which the doctor agrees to treat the patient and the patient agrees to pay the doctor's fee for treatment. As a courtesy we will assist you by filing your claim to your primary insurance company for all office visits. On the day of surgery you will pay your estimated portion of the total fee. Keep in mind, this amount is based on what your insurance company has told us regarding what they will pay for the surgery.

Please remember, these are only estimates and are not always accurate. If we are misquoted by your insurance company, we are not responsible for their mistake and you will be billed based on your insurance company explanation of benefits. A pre-treatment estimate can be sent by our office to your insurance company and is the most accurate estimate that can be obtained. If you would like to wait on a pre-treatment estimate, please inform our office. Once insurance has paid, you will be billed or refunded accordingly.

For the purpose of filing claims/Insurance verification, I authorize the release of any information and I assign benefits to the doctor. By signing below, I agree to the above terms of financial responsibility.

_____ _____
Signature of Patient or Authorized Representative Date

Alliance Oral & Maxillofacial Surgery, P.A.

Patient Name: _____

Due to Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually. TODAY'S DATE: _____.

I authorize Alliance Oral & Maxillofacial Surgery, to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care. O YES / O NO

In the event a family member or caregiver attends your office visit and is in the exam room at the time of your evaluation, I give Alliance Oral & Maxillofacial Surgery and it's physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person. O YES / O NO

I authorize Alliance Oral & Maxillofacial Surgery to leave a voice messages with treatment information in case I can't be reached to discuss at the moment of the call.

HOME PHONE: _____ Leave a message: O YES / O NO
WORK PHONE: _____ Leave a message: O YES / O NO
CELL PHONE: _____ Leave a message: O YES / O NO

May we call your name out loud in our lobby? O YES / O NO

With whom may we discuss or release information about your care and treatment?

Name: _____ Relationship: _____
Name: _____ Relationship: _____

With whom may we <u>not</u> discuss or release any information about your care and treatment?

Name: _____ Relationship: _____

Patient or Authorized Representative Signature:_____
(Signature is valid one year from date shown above)

Printed Name: _____

Alliance Oral and Maxillofacial Surgery, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Patient or Authorized Representative Signature

_____
Print Name

_____
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:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____

ALLIANCE ORAL & MAXILLOFACIAL SURGERY, P.A.

FINANCIAL POLICY

Patient care is always our first priority. We take pride in delivering the finest care at a reasonable cost. For that reason it is important to have a good understanding regarding our office financial policies and your responsibilities.

INSURANCE PROCESSING

Your insurance coverage is determined by your insurance plan, and it's your insurance company that decides your benefits. We are not responsible for any limitation in coverage that may be included in your plan. The financial obligation for our services rests on you.

As a courtesy to our patients we will file up to two insurance claims (dental-dental / medical-dental). If you have a secondary dental insurance that requires medical denial, only primary insurance will be filed and you will be responsible for the balance. You can then file directly with your secondary insurance. We will gladly provide you with a copy of your itemized statement.

Please understand that even if you do have more than one medical and/or dental insurances, you might still have a deductible, co-insurance and/or co-pay obligation. **It is your responsibility to pay any denied or unpaid balance in full.**

PLEASE READ CAREFULLY

- ☐ As a courtesy to our patients, our office will file up to two insurance claims on your behalf.
- ☐ If the primary insurance says the patient owes $50 or less, or if your primary insurance pays an amount that exceeds the benefits of the secondary insurance, a secondary claim will not be submitted and the patient will be responsible for the balance. You can then file directly with your secondary insurance. We will gladly provide you with a copy of your itemized statement.
- ☐ Insurance companies often consider **IV sedation** as a not covered benefit for extractions and biopsies. If your insurance disclosed that sedation won't be covered, we will not file insurance for those charges. We will honor your insurance contracted fees even if you are not covered for IV sedation.
- ☐ Any treatment plan's **estimated** co-payments or deductible amounts (patient portion) are due at time services are performed.
- ☐ If your insurance is terminated **prior** to surgery, you will be responsible for the procedure at regular office fees.
- ☐ If your insurance company **misquotes** your benefits to us, we are not responsible for their mistake. You will be billed for any amounts not covered according to insurance explanation of benefits.
- ☐ Since your available benefits may change, treatment plan estimates are **valid 30 days** from the date of your consult. It's your insurance that determines your financial responsibility.
- ☐ Your insurance company may refuse payment of your claim, in which case you will be responsible for the entire bill.
- ☐ The best way to obtain the most accurate quote from your insurance company is to send a **pre-treatment estimate or pre-determination**. Insurance estimates may take 3 to 6 week to be processed. They are not a guarantee of coverage or payment. You may request the pre-treatment / pre-determination from our Treatment Coordinator **before** you leave your consult appointment.

ATTENTION PATIENTS WITH OUT OF NETWORK INSURANCES

If our providers are NOT in-network with your insurance plan, all procedures will be processed by your insurance as out-of-network. This means you will have to pay based on out-of-network coverage % and the explanation of benefits (EOB) from your insurance company won't necessarily match your financial responsibility with our office.

Even if we are informed that you have out-of-network benefits under your insurance company, certain types of plans will not pay any money if the patient requests and seeks services from a non participant provider. **It is your responsibility to confirm this information with your insurance provider.**

ALLIANCE ORAL & MAXILLOFACIAL SURGERY, P.A.

ATTENTION MEDICARE PATIENTS

We are not MEDICARE providers, for that reason **we can not file claims** to supplemental medical insurance for patients covered under Medicare. If you have a separate dental coverage, and your procedure is considered dental, we will verify your insurance benefits and quote our services accordingly. If a Medicare explanation of benefits is required for any dental or medical procedures, patient will be responsible for the full balance.

SELF PAY PATIENTS

Your treatment plan estimate will be valid for 60 days from the day you sign your estimate.

SCHEDULING POLICY

A **$50.00** surgery scheduling fee will be charged when a patient schedules surgery. This fee will be applied to patient's balance once insurance is processed. If patient does not comply with our cancellation policy, the **$50.00** surgery scheduling fee will be forfeited. For surgeries that require three or more hours, a customized schedule fee will be requested at the time of scheduling.

Because your schedule may change, if your appointment is more than two months in the future, we will need to verify that you want to keep that appointment closer to surgery. We will need to confirm your appointment 7-14 days prior to surgery. We will try to contact you during this time frame. If we receive no call or reply from you within one week of surgery, the appointment will be cancelled and there will be no refund of your scheduling fee. If we are able to contact you but the original surgery date no longer works, our scheduling fee can be refunded or applied to another appointment date.

CANCELLATION POLICY

If you must cancel or reschedule your surgery, please allow at least 48 hours notice. There will be a late cancellation charge that equals your scheduling fee, if you no-show, cancel or reschedule your surgery with less that 48 hours notice. If proper notice is not given or you simply do not show up for your appointment, and you would like to re-schedule your procedure, you will be required to pay your entire estimated amount for the procedure prior to being placed back on the surgery schedule.

PAYMENTS POLICY

For your convenience, we accept Visa, MasterCard, Discover, debit card (Visa or MasterCard logo), money orders and cash. If one of these are not an option for you, you can apply for Care Credit, which is a third party payment plan alternative. **Personal checks or American Express, won't be accepted as a method of payment.** If patient pays a final balance by mailing a check, and check is returned as "insufficient funds", a fee of $25 will be added to your balance.

A patient's account remains due and payable within 30 days after the insurance processes your claim. If it becomes apparent that the patient does not intend to satisfy their unpaid balance, a collection agency may be employed to pursue collection of the account. The patient will be charged and held responsible for all collection fees incurred by Alliance Oral & Maxillofacial Surgery in collecting the debt. Those charges will be automatically added to the patient's account. Once your account is transfer to a collection agency, our office won't be able to process any payments.

I have read and understand my financial obligations as a patient / authorized representative. I acknowledge that I am fully responsible for providing correct insurance information and payment for all services not covered by my insurance company for any reason.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print

COVID-19 PANDEMIC PATIENT DISCLOSURES

Patient's Name _____ Date of Birth _____

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Pre-Appointment		In-Office	
	Yes	No	Yes	No
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐	☐	☐
Have you tested positive for COVID-19?	☐	☐	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐	☐	☐
Have you traveled outside the United States or to high-risk areas in the past 14 days?	☐	☐	☐	☐
Do you have a fever or above normal temperature?	☐	☐	☐	☐
Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? _____	☐	☐	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐	☐	☐
Do you have a cough?	☐	☐	☐	☐
Do you have a runny nose?	☐	☐	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐	☐	☐
Do you have a sore throat?	☐	☐	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐	☐	☐
Do you have muscle pain?	☐	☐	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐	☐	☐
Do you otherwise feel unwell?	☐	☐	☐	☐

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COVID-19 PANDEMIC PATIENT DISCLOSURES

Patient's Name _____ Date of Birth _____

I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Patient or Legal Representative Signature _____ Date _____

Print Patient or Legal Representative Name/Relationship _____

Witness Signature (optional) _____ Date _____

Alliance Oral & Maxillofacial Surgery
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