Cusumano
Oral Surgery & Implant Center

Thank you for choosing Cusumano Oral Surgery & Dental Implant Center!

PATIENT NAME: **DOB**: **AGE :** **«Account Number»**

CONTACT INFORMATION	Street Address_____ City _____ State _____ Zip_____ o Home Phone: _____ o Mobile Phone: _____ **Please check box next to best contact number** o Single o Married (check one) Email Address: _____ Social Security #: _____
EMPLOYMENT INFORMATION	Company Name _____ Occupation _____ Phone #_____ Address _____ City _____ State _____ Zip _____
RESPONSIBLE PARTY	Name _____ Social _____ DOB_____ Employer Name _____ Occupation _____ Phone # _____ Address _____ City _____ State _____ Zip _____
INSURANCE INFORMATION ***Primary Dental Insurance***	Insurance Company Name: _____ Effective Date _____ Policy # _____ Group # _____ Primary Insured's Name _____ DOB _____ Primary Insured's Place of Employment _____ Phone Number _____ Do you have additional dental insurance? ¨ Yes ¨ No ***(if so, please list below)***
INSURANCE INFORMATION ***Secondary Dental Insurance***	Insurance Company Name: _____ Effective Date _____ Policy # _____ Group # _____ Primary Insured's Name _____ DOB _____ Primary Insured's Place of Employment _____ Phone Number _____ Do you have additional medical insurance? ¨ Yes ¨ No ***(if so, please list below)***
INSURANCE INFORMATION ***Medical Insurance***	Insurance Company Name: _____ Effective Date _____ Policy # _____ Group # _____ Primary Insured's Name _____ DOB _____ Primary Insured's Place of Employment _____ Phone Number _____
How Did You Hear About Us?	o Yellow Pages o Online Yellow Pages o Google o Yahoo o Bing o Internet o Pharmacy Bag o Newspaper o Dentist: _____o Friend: _____
Emergency Contact Information	Emergency Contact _____ Phone # _____ Present Complaint: _____Primary Dentist: _____ Practice Name: _____Location: _____
ASSIGNMENT & RELEASE	I hereby authorize the use of this signature on all my insurance submissions. I further authorize Francis J. Cusumano, DDS, PA to forward any information necessary to said insurance company for payment of my insurance claims. If I have provided my email address above, I further authorize Francis J. Cusumano, DDS, PA to contact me via email for appointment reminders, etc. _____ _____ Signature of Insured/Guardian Date

Thank you for choosing Cusumano Oral Surgery & Implant Center for your oral surgery needs! Please review the following policies, and feel free to ask if you have any questions or concerns. We look forward to taking care of you!

Account #:

FINANCIAL AGREEMENT

Payment for services is 100% my responsibility • Payment is due at the time of service • Current dental insurance information and/or a current dental insurance ID card & picture ID is required to process insurance • If my dental insurance cannot be verified or if I do not have insurance, I will pay in full with cash, check or credit card (MasterCard, Visa, American Express or Discover) at the time of service• Return Check will incur a fee of $50 • **Payments over $300 by credit card or debit card will incur a credit card service charge of 3.0% of the total amount paid**• We request a deposit be made to reserve treatment appointment• If the patient amount due is less than $100 I will be asked to pay in full to reserve appointment • Treatment over $100- Fifty percent (50%) of patient responsibility (amount not covered by insurance) is expected to reserve appointment • The fees quoted represent the fees of our surgeons only • I may receive a separate bill from any other medical providers participating in your care. • I understand that my insurance contract agreement is between the insurance company and me, and not Dr. Cusumano and insurance company. We file with insurance company as a courtesy to our patients • Pre-authorization or Pre- determination may be required by your insurance provider and is not a guarantee of payment • You may request a Pre-determination prior to surgery otherwise we give you an estimated cost per your insurance eligibility• Copayment are accepted for procedures if a pre-determination from your insurance carrier is on file, otherwise payment is expected in full • Failure of your insurance carrier to reimburse your account within thirty (30) days will result in our office billing you directly for any balance • You are ultimately responsible for account resulting from unanticipated circumstances regarding insurance coverage and the final determination will be made by your insurance company at the time the claim is processed • In case of default patient and/or responsible party are liable for any and all collection and/or responsible attorney fees• You will incur a fee of $50 if you account is sent to Audit Department for nonpayment• We do offer third party financing Please inquire with one of our Patient Care Coordinator • It has been explained to me that during the course of surgery unforeseen conditions may be revealed which will necessitate extension of the original procedure or a different procedure. I authorize my doctor and his staff to perform such additional procedures as is necessary and desirable in the exercise of professional judgment. I do understand that additional charges may be incurred • By signing I state that I have read, understand, and agree to the financial agreement.

_____ _____ _____

Patient Name *(Please Print)* Patient or Guardian Signature Date

CANCELLATION POLICY

I understand that, if I am unable to keep my scheduled appointment for any reason, I will notify the office at least twenty-four (24) hours in advance of my scheduled appointment time. I am aware that I may be charged a $50 cancellation fee if I do not provide twenty-four (24) hours notice of cancellation or do not show up for the appointment. Surgery appointment are scheduled well in advance. We reserve one to two hours for surgery treatment therefore we ask if you are unable to keep appointment give us at least twenty-four (24) hours notice of cancellation. I understand that there maybe a charge of 1/2 the treatment plan for broken surgery appointments.

_____ _____ _____

Patient Name *(Please Print)* Patient or Guardian Signature Date

HIPAA

By federal and state law, we are required to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to these.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please list names: 1. _____ 2. _____

By signing below, I certify that I have read, understand and agree to the financial and office policies stated above. I have acknowledged the Notice of Privacy Practices for Cusumano Oral Surgery & Implant Center, and a copy has been made available to me. I consent to receiving communication via methods checked 'yes' above, and agree to allow any listed family members to discuss my medical condition

_____ _____ _____

Patient Name *(Please Print)* Patient or Guardian Signature Date

PATIENT NAME: _____ **DOB:** _____ **AGE:** _____

Primary Care Physician's Name: _____ ___ None Physician's Telephone Number: _____ - _____

Specialist Physician Name: _____ ___ None Specialist's Telephone Number: _____ - _____
Cardio, Pulmonary, OB/GYN, Oncologist Other:

Circle YES or NO and answer all boxes.

Patient reported Medical Health History: **BP _____ Pulse _____ Pulse Ox: _____ Weight _____lbs. Height _____inches. BMI: _____**

Yes No Anxiety Dental	Yes No Acid Reflux Disease	Yes No AIDS / HIV Positive	Yes No Allergy/Sinus Problems
Yes No Anemia	Yes No Arthritis	Yes No Asthma Last ER visit:	Yes No Blood Disorder/Disease
Yes No Blood Pressure High	Yes No Blood Pressure Low	Yes No Cancer	Yes No Chemical Dependency
Yes No Chemotherapy	Yes No Colitis	Yes No Diabetes: Insulin Last ER visit:	Yes No Diabetes Pill Controlled Last ER visit:
Yes No Difficulty Breathing Reason:	Yes No Fainting Spells/Dizziness	Yes No Glaucoma	Yes No Heart Attack
Yes No Heart Murmur	Yes No Heart Trouble / Irregular beat	Yes No Heart Valve Replacement	Yes No Hepatitis or Liver Disease
Yes No High Cholesterol	Yes No Immune Disorder	Yes No Kidney Trouble	Yes No Mitral Valve Prolapse
Yes No Osteoporosis	Yes No Pace-Maker	Yes No Psychiatric Disorder Yes No Depression	Yes No Radiation Treatment
Yes No Rheumatism	Yes No Rheumatic Fever	Yes No Seizures	Yes No Sleep Apnea ___ CPAP __ Face or __ Nasal
Yes No Skin conditions / Rash	Yes No Stomach Ulcers Date:	Yes No Stroke	Yes No Thyroid Problems
Yes No Vision Problems Yes No Contact lenses	Yes No Knee Replacement Yes No Hip Replacement	Yes No Pain Management program/contract	Yes No Recreational Drug Use List drug(s)
TMJ Problems: Date began: Clicking Popping Grinding Painful opening Bruxism appliance Difficulty eating	**MD recommendes Antibiotic PRE-MEDICATION:** Yes No Not sure	Yes No Have you been prescribed narcotic pain medication in the past 30 days?	Yes No Chronic Health Disorder(s) or Conditions.
Bisphosphate drug use: Atelvia (Actonel) Alendronate(Fosamax) Ibandronic (Boniva) Zoledronic(Reclast/ Zomeda) Other: **RANK** drug use: Denosumab(Prolia / XGEVA) Other:	Do you use **Blood Thinners:** Aspirin Eliquis Plavix Warfarin /Coumadin Xaralto Pradaxa other: Are you able to stop bloodthinner(s) prior to denal or hygiene procedures? Yes No Not sure	**Habits:** Smoke _____ cigarettes/day, _____ years Quit? Chew Tobacco ___ years Quit? Drink Alcohol, ____ drinks/week.	**ALLERGIES:** Penicillin Sulfa Codeine Hydrocodone Other: Adverse reactions = GI upset/ Nausea/ Vomiting Yes No
Additional Comments:		**WOMEN ARE YOU PREGNANT, OR IS THERE ANY CHANCE YOU MAY BE PREGNANT?** No Yes , Weeks Pregnant _____ Currently Using Birth Control Pill Entered Menopause at age _____	

SURGERIES: List hospitalizations or any medical/dental surgeries? Any history of anesthesia complications: Yes No. Prior dental IV anesthesia Yes No.
No Medical Surgery
No Dental Surgery

Medication(s) List Provided **Unsure: Contach Health Provider/pharmacy for more information.**

PATIENT NAME:__{«MERGEFIELD FullName»}_____ DOB:__**{«MERGEFIELD BirthDate Format="MM/dd/yyyy"»}**_ AGE**: {«MERGEFIELD AgeNoMonths»}**

In the past 12 months, have you been hospitalized or had and change(s) in health or medical condition(s) Yes No

Yes No **Chest pain** Yes No **Shortness of breath or Breathing /Lung problems** Yes No **Serious illness** **Other**

I understand that I am providing the complete medical history. I am aware that by not accurately reporting and discussing my knowledge of my medical history and medications/drug use can have serious consequences during/after dental care and dental anesthesia.

Patient / Guardian: _____ **Date:** _____

DDS Office Notes: ASA Class _____ Malampatti Airway Class _____ Any Anesthesia complication history: No Yes , explain below

MRS needed prior to surgery No Yes Cardiac Stroke HTN Diabetes Lung Immune Anticoagulation Unclear historian Other:

Stop blood thinners or ASA 3-5 days prior Premedication Update Medical History & Medications Cardiac assessment Diabetic Respiratory Medical recommendation for:

Dentist: _____**Date:** _____

Assistant: _____

DDS update notes: