ASSOCIATES IN MAXILLOFACIAL & ORAL SURGERY

NEW PATIENT INFORMATION (PLEASE PRINT)

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Nickname: _____

Date of Birth: _____ Social Security #: _____ Sex: ○ M ○ F

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated Preferred Primary language: _____

Mailing Address: _____
CITY STATE ZIP

Street Address (if different): _____
CITY STATE ZIP

Primary Phone: _____ H W M Secondary Phone: _____ H W M E-mail: _____

Employer: _____ Occupation: _____

Are you a student? ○ Full ○ Part School Name, State: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Who is your? Dentist: _____ Orthodontist: _____ Physician: _____

Who were you referred by? ○ Dentist ○ Orthodontist ○ Physician ○ Insurance ○ Web ○ Family/Friend ○ Phone

RESPONSIBLE PARTY (IF OTHER THAN PATIENT):

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____ Social Security #: _____

Relationship to patient: _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

INSURANCE (PLEASE PRESENT MEDICAL/DENTAL CARDS FOR PHOTOCOPY):

PRIMARY COMPANY:

Insurance Name: _____

Insurance Address: _____

Group #: _____ ID #: _____

Policyholder: _____

Address: _____

Insurance Phone: _____ Date of Birth: _____

○ Medical ○ Dental ○ Auto Other: _____

SECONDARY COMPANY:

Insurance Name: _____

Insurance Address: _____

Group #: _____ ID#: _____

Policyholder: _____

Address: _____

Insurance Phone: _____ Date of Birth: _____

○ Medical ○ Dental ○ Auto Other: _____

CERTIFICATION OF INFORMATION:

We make every effort to keep the cost of your surgical care down. Payment arrangements can be made with our Financial Coordinator depending upon special circumstances. An ***ESTIMATE*** of the charge for any procedure or surgery you may require will be given to you. If you have medical and/or dental insurance, we will be glad to file a claim on your behalf. Please complete the insurance section above.

Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance and any other balance not paid by your insurance company. Past due balances are subject to a monthly finance charge.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits form unless otherwise stated payable to me.

Signature: _____ Date: _____

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SELF PAY PLANS

- Patients who are not participating in some type of insurance plan will be expected to pay at the time of service or make arrangements for payment at the time of service.
- Interest-Free Financing is available to AMOS patients through Care Credit. This financing is available for all AMOS patients who qualify through this institution. AMOS will be happy to assist any patients interested in this financing option.

INSURANCE PLANS

- AMOS is a contracted provider for many insurance plans. We are happy to submit claims for payments to your plan for reimbursement. Please be aware of the following:
- **Prior authorization of your treatment is not a guarantee of payment. Your insurance company may deny some or all of the services provided regardless of prior approval.**
- **Financial estimations provided by us for any procedures with a remaining balance after proposed insurance coverage are ESTIMATES ONLY and not a guarantee of your portion due. The information gathered from your insurance company is not a guarantee of payment and claims are subject to review once received.**
- Please remember that insurance is considered a method of assisting in the cost of care. Some insurance plans have a fixed fee schedule and other plans pay a percentage of the AMOS standard fee schedule. AMOS will gladly assist in filing a claim on your behalf. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid by your insurance company. All remaining account balances after final insurance reimbursement will be the responsibility of the guarantor and will be due and payable within thirty (30) days of the receipt of a statement from AMOS.
- If AMOS is not a contracted provider for your insurance plan; AMOS will also file a claim on your behalf. The reimbursement for the service provided would be based upon AMOS' standard fee schedule. Any difference between the rate paid by your insurance company and AMOS' standard fees will be the guarantor's responsibility. This will be due and payable thirty (30) days from receipt of a statement from AMOS.
- AMOS will allow sixty (60) days for your insurance company to satisfy your account. It will be your responsibility to follow up with your insurance company to be certain that your reimbursement will occur in a timely fashion. If your insurance company has not reimbursed AMOS within sixty (60) days, your account balance will be due and payable immediately.

TERMINATION OF SERVICES

- Please be aware that you have the right to terminate our services at any time after consulting with us. In such an event, you will be required to pay in full for fees incurred as of the termination date. This agreement also creates the right for us to terminate our services to you for any reason, including the failure to timely pay our statements in full as submitted or if we determine, in our discretion, that to continue our services would be unethical or impractical.

ACKNOWLEDGEMENT- RECEIPT OF NOTICE OF PRIVACY PRACTICES

- The privacy and protection of your patient information is of the utmost importance to AMOS. As required by the Federal Health Insurance Portability and Accountability Act (HIPAA) Regulations, a Notice of Privacy Practices must be provided by all healthcare providers to their patients. At AMOS a copy is clipped to the new patient paperwork clipboard and a copy will be provided upon request. AMOS reserves the right to modify the privacy practices outlined in the notice.

I authorize AMOS to release my protected health information to:

☐ **Yes** _____

(Name of person to whom information may be released)

☐ **No**

I have read and understand the above **financial policy** and by signing below, agree to abide by its guidelines. I have received or have been offered a copy of the **Notice of Privacy Practices** for AMOS and by signing below, acknowledge the same.

___ _____ _____/_____/_____ _____

Signature of Patient/Legal Guardian | Date | Relationship to patient (If Applicable)

ASSOCIATES IN MAXILLOFACIAL & ORAL SURGERY

MEDICAL HISTORY QUESTIONAIRE

DEMOGRAPHIC INFORMATION:

Name: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Physician: _____ Dentist: _____ Orthodontist: _____

MEDICAL HISTORY:

Are you presently under a physician's care, or have you been during the past 5 years including hospitalizations and ER visits? Yes No

If yes, please explain. _____

Yes	No		Yes	No	
O	O	Anemia	O	O	Hyperthyroidism or Hypothyroidism
O	O	Angina (Chest Pain)	O	O	Infective endocarditis
O	O	Artificial joint(s)	O	O	Kidney failure
O	O	Asthma	O	O	Mental health problems
O	O	Bleeding tendency (Bruise easily, abnormal or prolonged bleeding)	O	O	Migraines / Headaches
O	O	Cancer- Active or History	O	O	Mitral Valve Prolapse
O	O	Cardiac Stents	O	O	Myocardial Infarction (Heart attack)
O	O	Chemotherapy- Active or History	O	O	Are you nursing?
O	O	COPD	O	O	Obstructive sleep apnea
O	O	Defibrillator (Heart)	O	O	Osteoarthritis or Rheumatoid arthritis
O	O	Diabetes Type I or Type II	O	O	Osteoporosis or Osteopenia
O	O	Dialysis	O	O	Pacemaker (Heart)
O	O	Emphysema	O	O	Are you pregnant? Which trimester:
O	O	Epilepsy (Seizures)	O	O	Radiation therapy- Active or History
O	O	GERD	O	O	Rheumatic fever- Active or History
O	O	Heart disease	O	O	Seasonal allergies or Sinusitis
O	O	Heart murmur	O	O	Sickle Cell Disease or Trait
O	O	Heart transplant or valve transplant	O	O	Snoring
O	O	Hepatitis A, B or C	O	O	Stroke / TIA
O	O	Hiatal hernia	O	O	Temporomandibular joint disease (TMD/TMJ)
O	O	HIV/AIDS	O	O	Tuberculosis- Active or History
O	O	Hypertension (High blood pressure)	O	O	Ulcers- Stomach

MEDICATIONS:

Please list any and all medications that you are presently taking (antibiotics, pain medication, heart medicine, anti-coagulants, vitamins, herbal remedies):

_____

Please list medications you have taken or are currently taking, for osteoporosis or cancer (Fosamax, Actonel, Boniva, Reclast, Zometa, Aredia, Prolia, Xgeva):

_____

ALLERGIES:

Yes	No		Reaction:	Yes	No		Reaction:
O	O	Local anesthetics (lidocaine)	_____	O	O	Codeine/narcotics	_____
O	O	General anesthetics	_____	O	O	Penicillin, Sulfa Drugs	_____
O	O	Aspirin	_____	O	O	Latex	_____
O	O	Soy, nuts or eggs	_____	O	O	Others (please list):	_____

SOCIAL HISTORY:

Have or do you smoke?	Yes	No	Packs per day:	_____	Years:	_____	Date when quit:	_____	
Do you use smokeless tobacco?	Yes	No	Use per day:	_____	Years:	_____	Date when quit:	_____	
Have or do you use marijuana?	Yes	No	Use per day:	_____	Years:	_____	Date when quit:	_____	
Other recreational drugs?	Yes	No	Number of years:	_____	Type:	Cocaine	Heroin	Meth	Narcotics
Do you use alcohol?	Yes	No	Drinks per day:	_____	Type:	Wine	Beer	Liquor	

SURGICAL HISTORY:

List any previous surgeries or procedures that you have had: _____

Nausea & Vomiting? Yes No Malignant Hyperthermia? Yes No Family History of Anesthesia Complications? Yes No

Prolonged Bleeding? Yes No Blood Transfusion? Yes No If yes, please specify: _____

HEALTH INFORMATION CERTIFICATION:

I hereby certify that the above information regarding the medical history of _____ (of the above stated patient) is complete, true, and correct and may be relied upon for all purposes by Associates in Maxillofacial and Oral Surgery, their assistants, colleagues, staff employees, and any other persons treating or assisting in the treatment of the patient.

SIGNATURE: _____ **DATE:** _____ **RELATIONSHIP (IF OTHER THAN PATIENT):** _____

SURGEON SIGNATURE: _____ **DATE:** _____

MED HISTORY UPDATE: _____ **PATIENT INITIAL:** _____ **REVIEWED BY:** _____ **BELOW THIS LINE: FOR OFFICE USE ONLY**

ALERTS MEDS ENTERED BY: _____ **REVIEWED BY:** _____