CONESTOGA ORAL SURGERY

Date _____

PATIENT INFORMATION

Name: _____/_____/_____ Date of Birth: ____/____ /____ Age: _____ Sex: M / F
First Name MI Last Name

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

Social Security #_____/_____/_____ Email: _____

Home Phone: (_____) _____ -_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Employer: _____ How did you find us (dentist, website, friend, etc.)? _____

Medical Physician: _____ Dentist: _____ Orthodontist: _____

Emergency Contact Name: _____ Phone Number: (____) _____-_____

GUARANTOR INFORMATION

Please complete if the patient is a MINOR or has a designated Power of Attorney (POA)

Name:_____/_____/_____ Relationship to Patient: _____
First Name MI Last Name

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

Date of Birth: _____/_____/_____ Social Security#: _____/_____/_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

PRIMARY INSURANCE INFORMATION

	MEDICAL INSURANCE	DENTAL INSURANCE
Company Name		
Insurance Address		
Insured Party		
Subscriber Employer		
Insured DOB		
Insured SSN #		
Relation to Patient		
Insured ID #		
Group #		

SECONDARY INSURANCE INFORMATION

	MEDICAL INSURANCE	DENTAL INSURANCE
Company Name		
Insurance Address		
Insured Party		
Subscriber Employer		
Insured DOB		
Insured SSN #		
Relation to Patient		
Insured ID #		
Group #		

HEALTH HISTORY

Name: _____ Age: _____ Height: _____ Weight: _____ Date: _____

Chief Dental Complaint: _____

1. Are you in good health?..... Y N
2. Have there been any changes in your general health in the last year? ..... Y N
3. Are you currently under a physician's care?..... Y N
   If yes, please specify: _____

_____

_____

4. Have you ever had any serious illnesses, operations, or hospitalizations?..... Y N
   If so, please describe: _____

_____

_____

5. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease..... Y N
   - B. Cardiovascular Disease (Heart Attack, Heart Murmur, Coronary Artery Disease, High Blood Pressure, Stroke, Chest Pain, Palpitations, Surgery, Pacemaker)..... Y N
   - C. Lung Disease (Asthma, Emphysema, Bronchitis, Chronic Cough, COPD, Pneumonia, Tuberculosis, Shortness of Breath)..... Y N
   - D. Seizures, Convulsions, Fainting/Dizziness..... Y N
   - E. Bleeding Disorder, Anemia, Blood Transfusion..... Y N
   - F. Liver Disease (Jaundice, Hepatitis) ..... Y N
   - G. Kidney Disease ..... Y N
   - H. Diabetes (Type I or Type II) ..... Y N
     Most Recent HbA1C: _____
   - I. Thyroid Disease ..... Y N
   - J. Arthritis ..... Y N
   - K. Gastrointestinal Disease (Ulcers, Colitis)..... Y N
   - L. Eye Disease/Glaucoma..... Y N
   - M. Osteoporosis..... Y N
   - N. Implants placed in your body (Heart valve, Joint Replacements) ..... Y N
   - O. Do you pre-medicate with antibiotics prior to dental procedures?..... Y N
   - P. Radiation/Chemotherapy treatment..... Y N
   - Q. Clicking/popping of jaw joint, ear pain, difficulty opening mouth, grinding or clenching teeth..... Y N
   - R. Sinus or Nasal Problems..... Y N
   - S. Any disease, drug, or transplant operation that has depressed your immune system..... Y N
   - T. HIV/AIDS..... Y N
   - U. History of Eating Disorder..... Y N
   - V. Sexually Transmitted Diseases (Please List)..... Y N

     _____
   - W. Psychiatric Disorders (Depression/Anxiety, Bipolar, Schizophrenia (Please List)..... Y N

     _____

6. ARE YOU USING ANY OF THE FOLLOWING:
   - A. Anticoagulants (*Coumadin, Plavix, Eliquis, Aspirin*)... Y N
   - B. Steroids (Cortisol, Prednisone, etc)..... Y N
   - C. Have you ever taken BISPHOSPHONATES for osteoporosis, multiple myeloma, or other cancers (*Reclast, Fosamax, Xgeva, Actonel, Zometa, Prolia*)..... Y N
   - D. Have you ever been advised not to take a medication Y N
     If so, please list _____
   - E. Please list ALL medications that you are currently taking including prescription medications, diet drugs, over-the-counter medications, herbal/holistic remedies, vitamins

     _____

     _____

     _____

     _____

     _____

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ADVERSE REACTIONS TO THE FOLLOWING:
   - A. Local Anesthesia (Novocain, etc)..... Y N
   - B. Antibiotics (Penicillin, Clindamycin, etc)..... Y N
   - C. Sedatives..... Y N
   - D. Aspirin or Ibuprofen..... Y N
   - E. Narcotics (Codeine, Hydrocodone, etc)..... Y N
   - F. Latex..... Y N
   - G. Food Products..... Y N
   - H. Additional allergies (please list)..... Y N

     _____

     _____

8. Do you smoke (cigarettes, cigars, marijuana), vape, or use chewing tobacco..... Y N
   How much per day? _____
9. Do you have any past history of alcohol or chemical dependence..... Y N
10. Has anyone in your family had any problems associated with anesthesia (Please List)..... Y N

    _____

11. Do you have any other disease, condition, or problem not listed on this form (Please List)

    _____

    _____

    _____

12. FOR WOMEN ONLY:
    - A. Are you pregnant, or is there a chance you might be pregnant..... Y N
    - B. Are you nursing..... Y N
    - C. Date of last period _____

I have read and understand the importance of a truthful and complete health history which will assist my oral surgeon in providing the best care possible. The information I have provided is comprehensive and accurate.

_____ _____

Date Signature of Patient/Guardian

CONESTOGA ORAL SURGERY

CONESTOGA ORAL & MAXILLOFACIAL SURGERY, LTD

Financial Policy and Agreement

We value our patients and are committed to the highest quality of care from our board certified oral surgeons. We are able to discuss our fees or office financial policy at any time with our patients.

A STATE-ISSUED PHOTO ID (such as a driver's license) and INSURANCE CARDS must be presented the day of your visit and will be photocopied for our records. This will allow us to assist you with your submission of any insurance claims.

IN-NETWORK INSURED PATIENTS: Insurance coverage is a benefit of the patient not our facility. It is your responsibility to know the specifics of your insurance policy. As a courtesy to our patients, we will obtain information available regarding your plan coverage and will provide an **ESTIMATE** of your expected out of pocket cost for the recommended treatment plan upon completion of your consultation. Our estimate will be as accurate as possible. Please understand that the fees paid by your insurance company are according to their own fee schedule, not necessarily the actual fees and cost of treatment performed by our office. Any estimated patient-owed monies will be collected by the front desk staff upon presenting for an appointment. Unfortunately, we may not be aware of your specific plans limitations. This may result in a payment that differs from our estimate or actual cost of your treatment.

Fees resulting from plan limitations and exclusions are the patient's responsibility and include items such as but not limited to: Missing tooth clause - Procedures which are not a benefit - Inaccurate information received from the patient - Annual benefit maximum being reached - Changes or termination of coverage

OUT-OF-NETWORK or SELF-PAY PATIENTS: A fee **ESTIMATE** will be provided to you on the day of your consultation for the itemized recommended treatment. Payment for treatment is due the day services are rendered. Fees will be collected by the front desk upon presenting to the office. If you are interested in receiving an estimate of reimbursement from your DENTAL insurance carrier prior to surgery, a pre-determination can be sent upon request. For patients with out-of-network dental and/or medical insurance, our office will happily submit the claim on your behalf to your carrier with all necessary documentation. This will allow you to maximize your benefit and expedite the reimbursement process. Payment from the insurance company will be received directly by the patient.

MEDICARE PATIENTS: We are non-Medicare providers. A fee estimate will be provided to you on the day of your consultation for the itemized recommended treatment. Payment for treatment is due the day services are rendered. Fees will be collected by the front desk upon presenting to the office. Unfortunately, we are unable to submit a claim on your behalf, however, we will provide you with an itemized receipt and additional Medicare paperwork that you are welcome to submit after treatment for any possible reimbursement you are eligible for.

MEDICAID PATIENTS: We are non-Medicaid providers. A fee estimate will be provided to you on the day of your consultation for the itemized recommended treatment. Payment for treatment is due the day services are rendered. Fees will be collected by the front desk upon presenting to the office. Unfortunately, we are not able to submit a claim on your behalf. Medicaid patients are required to go to a participating provider in order to receive any benefit and therefore, neither Conestoga Oral Surgery nor the patient can submit a claim for reimbursement due to our non-Medicaid provider status. Attempting to submit a claim may place the patients benefits at risk of revocation.

For payments in our office, we accept cash, personal checks, Visa, MasterCard, Discover, American Express, and Care Credit

- **I understand and agree that I am responsible for payment of all charges on my account regardless of any estimates of fees and/or insurance coverage**
- **For In-Network patients, I understand and agree that after my insurance carrier processes my claim(s), there could be a balance still remaining to be paid by me and must be paid immediately upon receipt of statement. I hereby authorize payments directly to Conestoga Oral & Maxillofacial Surgery, ltd. for insurance benefits otherwise payable to me.**
- **I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action including but not limited to collections agency fees, attorney fees, and District Justice fees.**
- **I understand that I am responsible for any fees as a result of a bad check and a that a claim will be filed with the Bad Check Restitution Program of the Lancaster County District Attorney's Office.**

Patient Name	Patient/Guardian Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I attest the "Notice of Privacy Practices" was made available to me (copy available upon request).

_____

(Print Patient 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 acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please specify)_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

HOME and/or CELLPHONE:

☐ Ok to leave message with detailed information
☐ Leave message with call-back number only
☐ Ok to give information to individual(s) listed below

WORK PHONE:

☐ Ok to leave message with detailed information
☐ Leave message with call-back number only

WRITTEN COMMUNICATION:

☐ Ok to mail to my home address
☐ Ok to fax

The following individuals may be contacted to discuss my medical care if necessary:

Name(s) Relationship Phone

1._____

2._____

3._____

This information will be considered current & valid unless otherwise notified

_____ _____ _____

Patient/Legal Guardian Signature Printed Name Date

CONESTOGA ORAL SURGERY

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