North Broward Oral Surgery

ORAL MAXILLOFACIAL & IMPLANT SURGERY

Thank you for choosing **Dr. Eric Fox and Dr. Ross Miller** for your oral surgical care. Our goal is to provide exceptional care in a safe and comfortable environment. Please complete this confidential form to help us better serve you. If you have any questions or need assistance, please let us know—we're happy to help.

PATIENT'S INFORMATION

Name: _____ Social Security#:_____

Address: _____ Apt: _____

City, State, Zip: _____

Date of Birth: _____ Home Phone: _____

Business Phone: _____ Mobile Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Patient's Marital Status: S M D W Patient's Gender: M F

Emergency Notification: _____ Contact #:_____

Spouses Name: _____ Contact #:_____

Dentist Name: _____ Referred By: _____

Physician's Name: _____ Contact #: _____

Pharmacy Name: _____ Pharmacy#: _____

BILLING INFORMATION (if different than above)

Person responsible for account: _____

Relationship to patient: _____DOB: _____ Social Security#: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____

INSURANCE INFORMATION

Dental Benefits

Insurance carrier: _____ Telephone: _____

Primary Holder's name: _____ Birth date: _____

ID or SS#: _____ Group#:_____

Medical Benefits

Insurance carrier: _____ Telephone: _____

Primary Holder's name: _____ Birth date: _____

ID or SS#: _____ Group#:_____

FINANCIAL POLICIES

Dr. Eric Fox and Dr. Ross Miller are participating providers with most **dental insurance carriers**. They are **not** participating providers with any medical insurance. However, some dental plans require us to coordinate benefits with your medical plan. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

We accept the following payment options for your convenience:

- Cash, Debit, Visa, MasterCard, American Express or Discover Card
- **We no longer accept personal or business checks**
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Payments, co-payments and deductibles are required to be paid in full at the beginning of your treatment.

We are happy to work with your dental insurance carrier to maximize your benefits and directly bill them for reimbursement for your treatment.[2]

All benefit information quoted is only an ***estimate*** and not a guarantee of payment. Any fee not covered by insurance is the patient's responsibility. We will send a statement notifying you of your unpaid balance.

Out of network benefits may be paid directly to the patient. If this occurs it is your responsibility to forward payment to Dr. Fox or Dr. Miller. Any benefit owed to Dr. Fox or Dr. Miller and kept by the patient is considered fraud and will be reported.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Patient's Name _____ Date of Birth _____ Height _____ Weight _____

Answer all questions by circling Yes (Y) or No (N). All responses are kept confidential.

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

   _____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation (X-ray) treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .....Y N
   - Q. Sinus or Nasal problems? .....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - S. HIV + / AIDS?..... Y N
   - T. Frequent or recurring mouth sores……Y N
   - U. Fibromyalgia……Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, etc.)? .....Y N
   - F. Tranquilizers .....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Zometa) ? ....Y N
   - J. **Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:**_____

     _____

     _____

     _____

     _____

     _____

     _____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products? .....Y N
   - G. Other allergies or reactions? Please, list.....Y N

     _____

9. Do you smoke, vape, or chew Tobacco? .....Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .....Y N
11. Have you had any serious problems associated with any previous dental treatment?.....Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
14. Do you wish to talk to the doctor privately about anything? .....Y N

15. **FOR WOMEN ONLY:**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some 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 medication is completed. Please consult with your physician for further guidance.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered to assist my dentist in providing the best care possible. I understand that providing incorrect information can be dangerous to my health.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

NORTH BROWARD ORAL SURGERY

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954-753-7070

PATIENT CONSENT FORM (HIPAA)
ACKNOWLEDGEMENT OF REVIEW OF ***NOTICE OF PRIVACY PRACTICES*** FOR PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20__

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____