Welcome to our Practice

Today's Date_____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. #_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ (FIRST NAME LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME)

Medical Dr._____ (FIRST NAME LAST NAME) Preferred Pharmacy_____ Tel.(_____)_____

Driver's Lic.#_____ Nearest relative not living with you_____ (FIRST NAME LAST NAME) Tel.(_____)_____

Employer_____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact_____ Tel. (_____)_____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME LAST NAME) S.S.#_____ Birth Date_____ Age _____

Tel.(_____)_____ Cell. (_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME LAST NAME) Relation_____ S.S.#_____ Birth Date _____

Street_____ Apt._____ City_____ State_____ Zip_____

Tel. (_____)_____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ N o t . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS CITY STATE ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS CITY STATE ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS CITY STATE ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS CITY STATE ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS CITY STATE ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS CITY STATE ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS CITY STATE ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS CITY STATE ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS CITY STATE ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS CITY STATE ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. # _____

Address_____ (ADDRESS CITY STATE ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS CITY STATE ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit?_____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year ?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of marijuana or other drug use?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 66–69)*

	Yes	No
66. Is there a possibility of pregnancy?	❑	❑
67. Expected delivery date?_____		
68. Are you nursing?	❑	❑
69. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
70. Any kind of medication, drug, pills?			
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
72. Have you ever taken diet pills?			
73. Any natural product, herbal supplement or homeopathic remedy?			
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			

75. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

76. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑Methadone ❑Suboxone ❑Oxycodone ❑Fentanyl ❑Other_____

Treating doctor:_____
First Name Last Name

77. Please list any medications you are currently taking:

Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home?_____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
78. Local anesthetic (numbing meds.)?			
79. Penicillin?			
80. Other antibiotics?			
81. Sulfa drugs?			
82. Sodium pentothal / Valium /other tranquilizers?			
83. Aspirin?			
84. Amoxicillin?			
85. Codeine or other narcotics?			
86. Latex?			
87. Soy?			
88. Eggs / yolk?			
89. Sulfites?			
90. Do you have any known allergies?			

91. Please list any allergies other than drug allergies:

92. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury_____

Insurance company handling the claim_____

Claim number_____

Name of attorney / adjustor_____

Telephone number (_____)_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ X_____ X_____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **reviewed by** **Date**

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon at the time of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for 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 or any other balance not paid for by your insurance company.** you will be responsible for all collection costs, attorneys' fees, and court costs.

X_____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

this signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ X _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

Authorization

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. in addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X_____ X_____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Doctor** **Date**

I hereby acknowledge that a copy of this office's notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

ROLLA ORAL SURGERY & PERIODONTICS FINANCIAL POLICY

PAYMENT FOR SERVICE

The payment for medical and dental services is the patient's responsibility. Our policy requires payment at the time the service is performed. If other arrangements are needed, please ask so that we may assist you. **We do not accept temporary or post-dated checks. A $20.00 fee will be assessed on returned checks.**

INSURANCE

Verification of benefits is not a guarantee of payment by your insurance company; final determination is made by your insurance company at the time the claim is received.

- **CONTRACTED INSURANCE PLANS (HMO, PPO, DMO, etc.)**
  - If our office has a contract with your insurance company, we will file all claims with them. You are responsible for payment of an ***estimated deposit*** on your co-insurance or co-pay at the time of service. It is the patient's responsibility to obtain required authorizations from the insurance company or primary care physician for each visit. Failure to have a current authorization could result in (1) rescheduling your appointment or (2) payment in full for all services relating to this appointment.
  - *Per Missouri Statute Section 376.1226 for non-covered services no contract between a health benefit plan and provider shall require the dentist to provide services at a fee established by the health benefit plan.*
  - We are happy to file insurance claims for you (excluding Medicare or Medicaid), after verification of eligibility and benefits. Filing your claim does not take the place of your responsibility to pay for services rendered.

- **OFFICE VISIT/CONSULTATION**
  - An office visit/consultation with the Oral and Maxillofacial Surgeon is required for all patients that are referred to Rolla Oral Surgery & Periodontics. There is a cost to the consultation. Rolla Oral Surgery does not offer free consultations.
  - Many dental insurance companies have rules that only allow a certain amount of dental office visits per year. This is more commonly known as a "Frequency Limitation." Dental insurances do not differentiate a visit to your general dentist from a visit to a dental specialist, such as an Oral Surgeon. If the insurance company has not processed the latest dental visit claim from your referring provider then we have no way of knowing that the frequency limitation may have been met until we receive an explanation of benefits from your insurance company. Therefore, in this case, there would be a balance due from the patient for the Office Visit.

After we receive final payment or denial from your insurance company, you will be billed for the remaining balance on your account. If, after 60 days, your account remains unpaid by your insurance, you will be responsible for the balance. In the event of an overpayment on your account, a refund will be sent to you within 60 business days. It is important to recognize that your insurance policy is an agreement between YOU and your insurance company. Your benefit assignment does not take the place of your responsibility to pay for services rendered. If your balance is turned over to a third party for collections a 25% service charge will be applied.

In cases of divorced parents, the parent bringing the child to the initial visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I have read the above and understand that I am responsible for all office charges. I also understand that once payment has been received from my insurance company, any balance remaining on my account will be due within 30 days. I authorize the release of any medical or dental information necessary to process insurance claims and request payment of benefits to the provider of services. I understand that I will be responsible for all collection costs, attorney's fees, and/or court costs.

Name of Responsible Party (Please Print)

Signature of Responsible Party **Date**

Patient Name if different than the Responsible Party

William T. Burns, D.D.S.

Mitchell D. Esquibel, D.D.S.

ROLLA
Oral Surgery & Periodontics

CONSENT TO RELEASE INFORMATION

Patient:_____ **Date of Birth:** _____

I understand that it is my responsibility to provide authorization to Rolla Oral Surgery in order to release any medical information regarding my care. I hereby authorize Rolla Oral Surgery to release medical information to the following:

_____	(Spouse)	_____	(Significant Other)
_____	(Parent)	_____	(Parent)
_____	(Sibling)	_____	(Child)
_____	(Friend)	_____	(Friend)
_____	(Employer)	_____	(Other)

By signing this release, I am authorizing any employee of Rolla Oral Surgery to either provide verbal or written information regarding my medical condition to the above named individual(s). Upon written notification this authorization may be cancelled by me at any time.

_____ _____

Patient or Legal Guardian Signature Date