

Commonwealth oral & facial surgery

Referred by Dentists | Preferred by Patients

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Birth Date: _____ Age: _____ Gender: _____

CONTACT INFORMATION

Mobile Phone _____ E-mail _____ Home Phone _____

Emergency Contact: _____ Contact Phone: _____ Relationship: _____

We send private health information such as appointment confirmation, procedure instructions, and financial information to your email, your cell phone, your answering machine/or your voicemail. Financial information is sent in an encrypted manner. Your information will only be used for necessary communication as described above. If there is any form of communication you wish not to receive, please communicate this below:

REFERRAL/PROVIDERS

Referring Doctor: _____ General Dentist (if other than referring doctor): _____

Medical Doctor: _____ Medical Doctor Phone: _____

RESPONSIBLE PARTY, FEES, AUTHORIZATIONS, AND ACKNOWLEDGMENTS

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 insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, copay, co-insurance, or any other balance not paid by your insurance company. If you do not have insurance, or your insurance does not cover the services rendered, payment in full is expected at the time of service.**

I hereby authorize the release of any information necessary to process my claim(s) and also authorize payment to the doctor otherwise payable to me.

I agree to pay all collection cost, attorney fees, filing fees, court costs, or other expenses incurred if my account is referred to a collection agency or attorney for collections. Attorney fees are to be assessed at 33.33% of the balance due. Please contact your insurance company 30 days after services are rendered to be sure your claim is being processed. Insurance reimbursement is ultimately the responsibility of the patient. In the event of an overpayment, a refund will be promptly issued to the person listed as the guarantor on the account.

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Self Spouse Father Mother Other

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ Apt: _____ City: _____

State: _____ Zip Code: _____

Mobile Phone: _____ E-mail: _____ Home Phone: _____

By signing below, I acknowledge I have read and understand the Commonwealth Oral & Facial Surgery financial policy above. I accept full financial responsibility of this account.

X _____ **X** _____ **X** _____

Signature of the Financially Responsible Party listed above Print Name

Date

Primary Insurance Information - Please provide complete information so that we may file your insurance claim

Primary Dental

Insurance Company _____ Insurance Phone Number: _____ Employer: _____

Member ID/Subscriber SS# _____ Group Number: _____

Subscriber Information

The Subscriber information may be different than the Patient information. The Subscriber is the person who pays for the insurance policy.

Subscriber First Name: _____ Subscriber Last Name: _____

Subscriber Date of Birth: _____

Relationship to Patient Self Spouse Parent Subscriber Gender Male Female

Are you covered by MEDICARE Part B? No Yes **Our Practice is OPTED OUT of MEDICARE. The Medicare Private Contract will be provided to you at the time of your appointment for more details.*

Primary Medical

Insurance Company _____ Insurance Phone Number: _____ Employer: _____

Member ID/Subscriber SS# _____ Group Number: _____

Subscriber Information

The Subscriber information may be different than the Patient information. The Subscriber is the person who pays for the insurance policy.

Subscriber First Name: _____ Subscriber Last Name: _____

Subscriber Date of Birth: _____

Relationship to Patient Self Spouse Parent Subscriber Gender Male Female

Secondary Insurance Information - Please provide complete information so that we may file your insurance claim

Secondary Dental

Insurance Company _____ Insurance Phone Number: _____ Employer: _____

Member ID/Subscriber SS# _____ Group Number: _____

Subscriber Information

The Subscriber information may be different than the Patient information. The Subscriber is the person who pays for the insurance policy.

Subscriber First Name: _____ Subscriber Last Name: _____

Subscriber Date of Birth: _____

Relationship to Patient Self Spouse Parent Subscriber Gender Male Female

Secondary Medical

Insurance Company _____ Insurance Phone Number: _____ Employer: _____

Member ID/Subscriber SS# _____ Group Number: _____

Subscriber Information

The Subscriber information may be different than the Patient information. The Subscriber is the person who pays for the insurance policy.

Subscriber First Name: _____ Subscriber Last Name: _____

Subscriber Date of Birth: _____

Relationship to Patient Self Spouse Parent Subscriber Gender Male Female

Preferred Pharmacy: _____ Location: _____ Phone: _____

Height: _____ Weight: _____

MEDICAL CONDITIONS			
CARDIAC	YES	NO	
Heart attack or stents			DATE:
Damaged or replaced heart valves			DATE:
Heart murmur			
Irregular heartbeat			
Pacemaker			
Heart surgery			Please explain:
High blood pressure			
RESPIRATORY	YES	NO	
Asthma			
Emphysema			
COPD			
Shortness of breath or lung condition			Please explain:
Sleep apnea			
CPAP			
ENDOCRINE	YES	NO	
Diabetes			Type:
Thyroid condition			
Immune system conditions due to medication or disease			

LIVER	YES	NO	
Hepatitis			Please explain:
Other liver problems			Please explain:
KIDNEY	YES	NO	
Kidney issues			Please explain:
Dialysis			
OTHER	YES	NO	
Cancer			Type:
Radiation or Chemotherapy			When:
Bleeding condition			Please explain:
Osteoporosis/Osteopenia			
Acid reflux/Stomach ulcers			
Mental health conditions			Please explain:
Communicable diseases			Please explain:
Artificial joint			Date:
TMJ			
Seizures			Please explain:

MEDICATIONS			
Do you routinely take any medications?	YES	NO	Please list all the medications you are currently taking:
GLP-1 agonist for diabetes and/or weight loss (Ozempic, Mounjaro, Zepbound, Byetta, Trulicity, Victoza, etc.)	YES	NO	Please list:
Bone density or chemotherapy medication (Fosomax, Boniva, Prolia, Xgeva, etc.)	YES	NO	Please list:
Blood thinner medication (Eliquis, Xarelto, Pradaxa, coumadin/Warfarin, Plavix, Brillinta, etc.)	YES	NO	Please list:

ALLERGIES		
Local Anesthesia (numbing medication)	YES	NO
Penicillin	YES	NO
Sulfa drugs	YES	NO
Morphine	YES	NO
Latex	YES	NO
Do you have any other allergies? Please list:	YES	NO

Intravenous (IV) anesthesia medications	YES	NO
Amoxicillin	YES	NO
Alpha-gel	YES	NO
Codeine	YES	NO

SURGICAL HISTORY

Have you ever had any kind of surgery?	YES	NO
In the last 5 years, have you been hospitalized, had surgery or treated for a major illness?	YES	NO
Have you ever had general anesthesia before?	YES	NO
Have you or a family member ever had issues with general anesthesia? Please explain:	YES	NO

SOCIAL HISTORY

Alcohol use	YES	NO
Past alcohol use	YES	NO
Marijuana	YES	NO
Current drug use	YES	NO
Current alcohol use	YES	NO
Tobacco	YES	NO
Other drug use	YES	NO
Past drug use	YES	NO

FAMILY HISTORY

Blood relative with head/neck cancer	YES	NO
Blood relative with bleeding disorder	YES	NO
Blood relative with heart disease	YES	NO

WOMEN

Is there a possibility that you are pregnant?	YES	NO
Are you currently breastfeeding?	YES	NO

A copy of this office's Notice of Privacy Practices is available on our website or by request. I acknowledge that I have been given the opportunity to ask questions that I may have regarding this notice.

- I do not wish to have my healthcare information disclosed to anyone
- I authorize disclosure of my healthcare information to the following individuals:

Name: _____ All Treatment Financial

Name: _____ All Treatment Financial

Name: _____ All Treatment Financial

X _____ **X** _____ **X** _____
Signature of the Patient (Parent or Guardian if Minor) Print Name Date

CERTIFICATION

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I understand the importance of a truthful health history to assist the doctor in providing the best care possible. The answers that I provided on the health history questions are an accurate representation to the best of my knowledge.

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. 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.

By signing below, I acknowledge that I have read and agreed to the terms listed above.

X _____ **X** _____ **X** _____
Signature of the Patient (Parent or Guardian if Minor) Print Name Date