Welcome to our Practice

PATIENT INFORMATION:

Today's Date_____

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

Dentist_____ _____ Orthodontist_____ _____ Medical Dr._____ _____
(FIRST NAME) (LAST NAME) (FIRST NAME) (LAST NAME) (FIRST NAME) (LAST NAME)

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

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_____ _____ S.S.#_____ Birth Date_____ Age_____
(FIRST NAME) (LAST NAME)

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_____ _____ Relation_____ S.S.#_____ Birth Date_____
(FIRST NAME) (LAST NAME)

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 ❑ Not . . . . . 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)

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 _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date** X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

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

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? If so, number of packs 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 ulcers / 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 drug abuse?			
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. 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
77. Local anesthetic (numbing meds.)?			
78. Penicillin?			
79. Other antibiotics?			
80. Sulfa drugs?			
81. Sodium pentothal / Valium /other tranquilizers?			
82. Aspirin?			
83. Amoxicillin?			
84. Codeine or other narcotics?			
85. Latex?			
86. Soy?			
87. Eggs / yolk?			
88. Sulfites?			
89. Do you have any known allergies?			

90. Please list any allergies other than drug allergies:

91. 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 (_____)_____

Mid-Cities Oral & Maxillofacial Surgery

Christopher King, DDS, MD
Board Certified Oral and Maxillofacial Surgeon
5209 Heritage Ave., Suite 220
Colleyville, TX 76034
(817) 900-3520

FINANCIAL POLICY

Payment Policy: We ask that you read through the financial policy and sign at the bottom prior to treatment. **Full payment is due at the time services. We accept CASH, CHECKS, CREDIT CARDS and CareCredit. Any balance that we submit to your insurance carrier is due to us, by you, if we have not received payment from your insurance carrier within 60 days from the date the services were rendered.**

There is a $50.00 fee charged for checks returned due to insufficient funds. You are responsible for any fees incurred in obtaining any unpaid balances which may include billing, collections or attorney fees.

Regarding Insurance: We participate with a number of dental insurance plans that we will contact to verify eligibility and benefits to strive to do so as accurately as possible, however you are encouraged to call your insurance to obtain benefit information. Some services may **not be covered by your dental insurance carrier** such as exams and radiographs (due to frequency limitations) or anesthesia depending on how your contract is written and you will be responsible for any out of pocket expenses at the time services are rendered. We will submit to most insurance plans as a courtesy to you and if we **do not participate with you dental insurance plan, payment may be sent directly to you.** Your insurance policy is a contract between you, your employer and the insurance company; we are not a party to that contract, and do not have the power to make the insurance company remit payment. You are responsible for providing the office necessary information concerning your insurance. If accurate information is not provided, this can delay payment – *regardless of benefits or coverage you are responsible for any amount unpaid by your insurance within 60 days from the date the services were rendered.*

Medicare/Medicaid Beneficiary's: We **are legally opted out** of Medicare/Medicaid and therefore you are responsible for the balance in full. Because we are legally opted out of Medicare, we or you are not able to submit the claim to Medicare. Medicare/Medicaid is usually primary and all other secondary insurances will not be billed thru our office.

Missed Appointments: We require that you give our office 48-hour notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $150.00 per hour scheduled will be charged to you**; this fee cannot be billed to your insurance company and will be your direct responsibility. Additionally, if a patient is more than 20 minutes late for a scheduled appointment, we will consider this a missed appointment and the $150.00 per hour scheduled cancellation fee will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

Minor Patients: Parents or Guardians are responsible for all charges for minor children.
Please let us know if you have any questions regarding our Financial Policy.

_____ _____

Signature of person financially responsible & relationship to patient — Please print patient's full name

_____

Date

Notice of Privacy Practices for Mid-Cities Oral and Maxillofacial Surgery

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect in 2018 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to obtain and provide information from specialists and other healthcare providers for services we provide to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in all owing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 for duplication of paperwork and $15.00 for duplication of radiographs. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities. If you request this accounting more than once in a 12 month period we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative mean or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by e-mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS If you want more information about our privacy practices or have questions or concerns please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend your restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may disclose my personal health information to the following:

_____	_____
Name/relationship	Contact information
_____	_____
Name/relationship	Contact information
_____	_____
Name/relationship	Contact information
_____	_____
Patient's Name	Date