Patient Name: ______________________

MEDICAL HISTORY:

YES/ NO Has there been any change in your general health in the past year?
YES/ NO Are you under a physician's care now? *If yes, Why?* ____
Physician's Name: _________________ Physician's Phone: _________________Date of LAST physical exam: __________
YES/ NO Have you ever been hospitalized or had any major operations? If yes, describe:___________________________________
YES/ NO Have you ever had a serious head or neck injury? If yes, describe: _______________________________
YES/ NO Are you taking any medications, pills, or drugs at this time? If yes, please list: ___________________________________
YES/ NO Are you allergic to any medications or substances? If yes, please select all that apply:
__ Aspirin/Blood thinners __Ibuprofen __Codeine __Penicillin __Novocaine __Sedatives __Latex __Other: ____________

PLEASE ANSWER THE FOLLOWING and (CIRCLE ALL THAT APPLY):

YES/ NO Rheumatic Fever OR Rheumatic Heart Disease?
YES/ NO Cardiovascular Disease? Circle any that apply *(High Blood pressure, heart attack, heart murmur, coronary artery disease,angina, stroke, palpitations, heart surgery, pacemaker, congenital heart disease)*
YES/ NO Lung disease? *(Asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain)*
YES/ NO Seizures, convulsions, epilepsy, fainting, dizziness, psychiatric treatment, or other nervous disorders?
YES/ NO Bleeding disorder, anemia, bleeding tendency, blood transfusion, bruise easily?
YES/ NO Liver disease *(Jaundice, Hepatitis A, B or C)*
YES/ NO Kidney disease?
YES/ NO Diabetes?
YES/ NO Hyperthyroidism or Hypothyroidism? Thyroid disease?
YES/ NO Arthritis?
YES/ NO Stomach Ulcers or colitis?
YES/ NO Glaucoma?
YES/ NO Implants anywhere in the body? *(Heart valve, pacemaker, hip, knee, and joint)*
YES/ NO History of cancer?
YES/ NO Radiation (X-ray) or Chemo Therapy treatments?
YES/ NO Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth?
YES/ NO Sinus or nasal problems?
YES/ NO Any drug, disease, or operation that has depressed your immune system?
YES/ NO Have you ever taken any bisphosphonate drugs? *(Reciast, Fosamax, Actonel, Boniva, Aredia, or Zometa)*
YES/ No HIV, AIDS, or ARC?
YES/ NO Do you smoke or chew tobacco? *(If yes, how much per day? ____________)*
YES/ NO Is there any history of alcohol or chemical dependency or emotional disorder that may affect the care that we provide to you?
YES/ NO Have you had any serious problems related to previous Dental treatment?
YES/ NO Have you or any immediate family member had any problems associated with intravenous sedation?
YES/ NO Do you have any other disease, condition, or problem not listed that you think the doctor should know about?
YES/ NO Do you wish to speak privately with the doctor about anything?
YES/ NO Other medical conditions: ____
Woman: Please select if applicable: __ Pregnant __Nursing __Taking Birth Control
Vitals: Height_______ Weight_______ Age: _______ ***Staff to complete: BP_______ Pulse_______***
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and the staff at the next appointment without fail.

X ____ X____________________________
Patient Signature Date

Reviewed by Doctor: ____ Date: ___________________________

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ORAL FACIAL SURGERY Specialists AT THE WOODLANDS

PATIENT INFORMATION

(Please Print and Complete)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

If you have given us your insurance information over the phone please disregard this part!

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize oral facial surgery center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

INSURANCE AGREEMENT

Our mission is to partner with our patients and community to achieve the best in dental health. In today's ever changing world of insurance, understanding each policy can be very challenging for the patient as well as your dental team. Every employer, along with the insurance company negotiates the benefits and exclusions of the insurance plans to come up with the best premiums for the employer and the employee. Sometimes in order for premiums to be affordable, the benefits offered by your insurance policy may not include everything that is needed to achieve the best for your dental health.

When doing a comprehensive exam, certain x-rays are necessary to diagnose properly. After your comprehensive exam has been completed, you will be provided with a detailed treatment plan that will have an estimate of the benefit your insurance may provide for each necessary service. With your treatment plan, you will receive the necessary information to verify the amounts with your insurance company. If you prefer, we can send a Pre-Determination of benefits to your insurance company to get a more exact figure; however, please be aware that this may delay treatment for approximately 4-6 weeks depending on your specific insurance company. After insurance receives the recommended treatment plan, they will determine the amount that will be due from the patient. A copy will be sent to the patient and the provider. As with all insurance claims and predetermination benefits, a disclaimer will be included stating it is still not a guarantee of payment.

Prior to your appointment, we do a call to verify your insurance and get a general break down of benefits. At this time we are informed that it is not a guarantee of payment, and or we may have to file to your Medical Insurance if needed, please understand though we are **NOT In-Network with ANY Medical Insurance**. It is a courtesy from our office to file to your insurance and it is not a requirement from us to file for you, any details of payment will ultimately become the responsibility of the patient.

In order to help you understand the insurance, below is a list of the most common exclusions:

- **Waiting periods: Some plans are set up to have waiting periods on certain procedures.**
- **Frequencies: A maximum number of times the will pay for specific procedures.**
- **Alternate benefit: In some cases, insurances may give an alternate benefit for services.**
- **Age limits: Insurance may only pay for a service up to a specific age.**
- **Missing tooth Clause: Treatment to replace teeth missing prior to the current plan may not be covered.**
- **Replacement Clause: Replacements of existing crowns, bridges, dentures, and partials.**
- **Maximums: Policy year varies by plan and will pay up to the maximum dollar amount per policy year.**

We encourage everyone to become involved in their insurance policy in order to avoid confusion after treatment has been performed. Please let us know if you have any specific questions that we can help you with.

By signing below, you are stating that you have read and understand that insurance is a contract between the policy holder and the insurance company. In the event of any unpaid balance, the patient will be financially responsible.

X____ X_______________________
PRINT PATIENT NAME DATE

X____ X_______________________
SIGNATURE OF PERSON RESPONSIBLE FOR ANY OUTSTANDING BALANCE DATE

PATIENT CONSENT FORM
(HIPAA)

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 (HIPPA). 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 used and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and 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 authorize The Woodlands Oral & Facial Surgery Center to release my medical information to the following person____, relationship to patient________________________.

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.

Print Patient Name: ____

Relationship to Patient: ____

Signature: __________________________________ Date_____________

It is important that you disclose any indication of having been exposed to COVID-19, or whether you have experience any signs or symptoms associated with COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Have you recently lost or had a reduction of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has been diagnosed with COVID-19?	☐	☐
Have you tested for COVID-19?	☐	☐
Have you been tested for COVID-19 and are waiting for results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air or bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge I have provided above true and accurate.

______________________________ Signature

______________________________ Date

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Pre-Operative Instructions

1. **NOTHING TO EAT OR DRINK 8 HOURS PRIOR TO SURGERY**. This includes ALL liquids including **WATER**.
2. You **MUST** have a person who is 18 years or older who can bring you to the appointment who has a valid ID. Your driver is **REQUIRED** to stay in the premises during the procedure and be available to take care of you up to 24 hours after the procedure.
3. Please wear comfortable clothing and shoes. **NO** contacts, jewelry, nail polish or long nails, dresses, long sleeves, high heels, or flip flops. Patients with long hair, please wear down with no hair clips or buns.
4. If your health history changes between now and the day of the surgery please let your surgeon know **BEFORE** surgery so we can accurately update your health history.
5. Your normal morning medications can be taken with a small sip of water 1 hour before your procedure.

   Example: High blood pressure, Thyroid, Heart and Psychiatric
6. You may need to be off work/school for 3-5 days. A work/school excuse is available if needed.
7. **DO NOT SMOKE/DRINK** , including marijuana and DO NOT USE ANY social drugs 48 hours prior to surgery.
8. Patients who are 17 and under MUST be accompanied by a parent or legal guardian. **NO EXCEPTIONS!**
9. **If you need to cancel or reschedule your appointment please give us 48 hour notice or a $50.00 fee will be charged to your account.**

Note: please call the office if symptoms of a cold, runny nose, fever/chills arise by the time of your surgery.
I acknowledge the receipt of and understand the instructions for intravenous sedation & general anesthesia.

Patient Signature: ____________________ Date: _______________

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Welcome to Oral Facial Surgery Specialists! Many procedures we provide require prescriptions; to make receiving your medications as easy as possible please provide us with your pharmacy information below.

Name of Pharmacy: ____

Address: ____

____

Phone: ____

Thank you so much for your assistance!

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