village pointe
ORAL SURGERY
& DENTAL IMPLANT CENTER

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I._____ Last Name _____ Nickname_____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Cell # _____ Home # _____

Street_____ City _____ State_____ Zip _____

Soc. Sec. # _____ E-mail _____

Dentist _____ _____ Medical Doctor _____ _____ Referred By _____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST NAME LAST NAME

Nearest relative not living with you _____ _____ Tel.(_____) _____
FIRST NAME LAST NAME

Employer_____ Bus. Tel.(_____) _____

Student: ❑ Full Time ❑ Part Time ❑ Not School Info _____
SCHOOL NAME ADDRESS

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____
CITY STATE ZIP

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other

(If self, skip to next section)

Name _____ _____ S.S.# _____ Birth Date_____ Age ____ Tel.(_____) _____
FIRST NAME LAST NAME

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Ins. Co. Name_____

Claim Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group #_____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address_____

_____ _____ _____
CITY STATE ZIP

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

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Ins. Co. Name_____

Claim Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group #_____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address_____

_____ _____ _____
CITY STATE ZIP

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

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Ins. Co. Name_____

Claim Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group #_____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address_____

_____ _____ _____
CITY STATE ZIP

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

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Ins. Co. Name_____

Claim Address _____
ADDRESS

_____ _____ _____ Tel.(_____) _____
CITY STATE ZIP

Group #_____

Insured Party _____ _____ Relation _____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date _____

Address_____

_____ _____ _____
CITY STATE ZIP

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

I.D. # _____

FEES AND PAYMENTS

Thank you for choosing Village Pointe Oral Surgery for your surgical care. Our mission is to deliver Village Pointe Oral Surgery for your dental care.
We make every effort to keep down the cost of your oral surgical care. Any new or ongoing visit may incur a fee.
An ESTIMATE of the charge for any procedure or surgery you may require will be given to you upon request.
If we are in network with your 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.

Returned Check Fee is 30 dollars. If prepaid services are not performed for any reason - the patient is subject to the following fees: CareCredit 16 percent reversal fee and 5 percent for Credit Card charges. These fees will be subtracted directly from any refund issued.

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

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.

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

CONTINUED ON THE NEXT PAGE - PLEASE FLIP OVER

Patient Name: _____ Please complete by checking "Yes" or "No", and filling in the blanks.

HEALTH HISTORY

Reason for Todays Visit? _____ **Age:** _____ **Weight:** _____

	Yes	No
Do you have a prosthetic joint/implant? _____ Heart Valve Replacement or Vascular Graft? _____	❑	❑
Do you have any BLEEDING PROBLEMS / BLOOD DISORDERS ? _____	❑	❑
Have you taken STEROIDS within the past year ? _____	❑	❑

Have you ever had any HOSPITALIZATIONS, SERIOUS ILLNESSES OR OPERATIONS?

If so, what? and when?

HAVE HAD OR CURRENTLY HAVE. . .

The answers you give to the questions below are medically necessary.

- ❑ Diabetes: Type I or Type II
- ❑ Artificial Heart Valve
- ❑ Heart Murmur
- ❑ Shunts: ❑ Venous ❑ Atrial
- ❑ Chest Pain ❑ Heart Failure
- ❑ Heart Attack(s) ❑ Stroke
- ❑ Irregular Heart Beat ❑ A-Fib
- ❑ Pacemaker ❑ Heart Surgery
- ❑ High Blood Pressure
- ❑ Shortness of Breath
- ❑ Smoke ❑ Chew Tobacco
- ❑ Asthma ❑ Lung Disease
- ❑ COPD ❑ Bronchitis
- ❑ Emphysema ❑ Sinus Problem
- ❑ Sleep Apnea
- ❑ Adrenal Disorder
- ❑ Difficutly Breathing
- ❑ Myasthenia Gravis
- ❑ Hepatitis: B or C
- ❑ Liver Disease ❑ Jaundice
- ❑ Tuberculosis
- ❑ Arthritis ❑ Joint Disease
- ❑ Epilepsy ❑ Seizure Disorder
- ❑ Alzheimers ❑ Dementia
- ❑ Hemophilia
- ❑ Pulmonary Embolism ❑ DVT
- ❑ Blood Clots ❑ Factor V
- ❑ Ulcerative Colitis ❑ Crohns
- ❑ Sickle Cell Disease ❑ Trait
- ❑ Dialysis ❑ Kidney Disease
- ❑ Thyroid Disease: Hypo/Hyper
- ❑ Glaucoma ❑ Eye Disease
- ❑ Contagious Diseases ❑ MRSA
- ❑ Mental Health Problems ❑ Anxiety
- ❑ Radiation ❑ Chemotherapy
- ❑ Cancer **Type:** _____
- ❑ Immunosupression possibly from medication or Transplant Surgery
- ❑ Neutropenia ❑ Delay in healing
- ❑ Osteoporosis ❑ Osteopenia
- ❑ Osteonecrosis
- ❑ Sexually Transmitted Diseases
- ❑ Alcohol Abuse ❑ Drug Abuse
- ❑ HIV Positive ❑ AIDS
- ❑ Infective Endocarditis

ASA I II III IV NOTES

WRITE DOWN lab values. . .

INR: _____ Date: _____

A_1C: _____ Date: _____

Other: _____

MEDICATION - Are you now taking or have you taken. . .

	Yes	No
Any kind of medication, drug, pills?		
Blood thinners - Coumadin, Plavix Aspirin, xarelto, Pradaxa, Eliquis, etc		
Anti Depressants, Sleeping Pills, etc?		
Bone Density / Bisphosphonates ? (Fosamax, Boniva, IV-Zometa, Actonel,Reclast, Skelid, Didronel Aredia, Prolia, xGeva?		

LIST MEDICATIONS

ALLERGIES - Are you allergic to, or had a reaction to. . .

	Yes	No
Local anesthetic (numbing meds)?		
Penicillin? Amoxicillin?		
Other antibiotics?		
Sulfa Drugs?		
Latex?		
Eggs / Yolk?		
Valium or other tranquilizers?		
Codeine or other narcotics?		
Other medications?		

LIST REACTION

FOR WOMEN ONLY

Is there a possibility of pregnancy? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Current Trimester: _____

It is recommended to avoid breastfeeding for 12 hours after IV sedation

Expected delivery date _____

Please Note:

Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance

In case of emergency, contact:

Name _____ Relationship _____ Tel (_____) _____

Is this visit related to an accident: Automobile ❑ Yes ❑ No Work Related ❑ Yes ❑ No Other ❑ Yes ❑ No Date of Injury _____

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 surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.
I certify that I am the patient or legal guardian/parent completing this form.

Print Name: _____

Signature of patient: X *(Parent or Guardian if minor)* **Reviewed by:** X **Date:** X

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.

X X

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

Witness: X

Doctor: X

PRIVACY NOTICE RELEASE

My personal health information is private and confidential. I understand that my doctor and his / her staf work very hard to protect my privacy and preserve the confidentiality of my personal health information. I understand that my doctor and his / her staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor may deny my request. If my doctor does agree to my request, I understand that my doctor and his / her staff would follow the agreed limits.

I may cancel this consent at any time by doing the following:

1. Signing and dating a written request to your doctor specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his / her staff do not have to provide any further care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice".

If I ask, my doctor or his / her staff will provide me with the most current "Notice" and the current "Notice" will always be available at my doctor's office. I give permission for the following individuals to have access to my private health information:

Name / Phone

Name / Phone

Name / Phone

Name / Phone

We may send private health information such as appointment confirmation, procedure instructions and test results to your email, your cell phone via text, your answering machine and / or your voicemail. If you choose to opt out of one of these methods, please mark below:

Email ☐
Text ☐
Answering Machine ☐
Voice Mail ☐

My signature below indicates that I have been given the chance to review a current copy of my Doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and healthcare options.