Fredericksburg Implant & Oral Surgery Associates

PATIENT #_____

PATIENT INFORMATION

Name _____

Date of Birth _____ Sex _____ Marital Status _____

Address _____

City _____ State_____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Employer Name _____

Employer Address _____

Guarantor _____ Relation to Patient _____

Referred By: General Dentist _____ Other _____

Preferred Pharmacy _____ Phone _____

If patient is a minor, please complete the following:

FATHER

Name _____

Date of Birth _____

Social Security # _____

Address _____

City _____

State _____ Zip Code _____

Preferred Phone _____

Work Phone _____

Employer Name _____

Address _____

_____

MOTHER

Name _____

Date of Birth _____

Social Security # _____

Address _____

City _____

State _____ Zip Code _____

Preferred Phone _____

Work Phone _____

Employer Name _____

Address _____

_____

EMERGENCY CONTACT

Name _____

Address _____

_____

Home Phone _____

Work Phone _____

Cell Phone _____

MEDICAL INSURANCE

Insurance Company _____

Identification # _____ Group # _____

Insurance Company Address _____

Phone _____

DENTAL INSURANCE

Dental Insurance Company _____

Identification # _____ Group # _____

Insurance Company Address _____

Phone _____

SUBSCRIBER (POLICY HOLDER INFORMATION)

Relationship to Patient _____ Social Security # _____

Name _____ Birth Date _____

Address _____

City _____ State_____ Zip Code _____

Employer _____

I authorize release of any information relation to this claim. I understand that I am responsible for all costs of treatment that is provided. I hereby authorize payment of the benefits otherwise payable to me directly to the below named entity.

Signed _____ Date _____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Fredericksburg Implant & Oral Surgery Associates may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, been offered, or had received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the practice and individuals involved in my care may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. I understand that I may obtain a copy of any current notice by contacting the office manager at (540) 371-4131.

I understand that I have the right to request that the practice restricts how my protected health information is used or disclosed for treatment, payment, or health care operations, but I also understand that the practice is not required to agree to a requested restriction. However, if the practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time except that the practice or individuals involved in my care have already used or disclosed protected health information in reliance on my prior consent.

Signed _____ Date _____ Relationship to Patient _____

FINANCIAL CONTRACT

In consideration for the professional services rendered now and in the future, the undersigned hereby agree to pay 18% interest per annum on all balances which are unpaid sixty (60) days after final insurance correspondence, plus attorney fees which are hereby stipulated to be 33 $^{1/3}$% of such outstanding balance whether suit is filed or not, plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned as may be necessary.

The undersigned understands that the Medical/Dental insurance claims may be billed by the provider as a courtesy if the provider participates in the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not the insurance coverage is available. In the event that the insurance denies payment for any service, patient is responsible for payment of said services in full.

In the absence of prompt payment, the undersigned understands that medical, personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the Federal "Health Insurance Portability and Accountability Act."

I, the undersigned, certify that I:

( ) am an active duty member of the U.S. Armed Forces

( ) am NOT an active member of the U.S. Armed Forces

Signed _____ Date _____

Relationship to Patient _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ Date of Birth _____

Many of our patients allow family members such as spouses, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medial or billing information released to family members, you must sign this form. Signing this form will only authorize the release of information to family members indicated below.

I authorize Fredericksburg Implant & Oral Surgery Associates to release my medical, billing, and/or appointment information to the following individual(s):

Name _____ Relation to Patient_____

Name _____ Relation to Patient_____

Name _____ Relation to Patient_____

I understand that I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law, and may be subject to re-disclosure by the above recipient. I understand that I have the right to revoke this consent in writing.

PREFERRED METHOD OF CONTACT

I authorize Fredericksburg Implant & Oral Surgery Associates to send information regarding fees and appointment information via email.

Email _____

I authorize Fredericksburg Implant & Oral Surgery Associates to leave messages regarding treatment, fees and appointment information via voice mail.

Phone _____ Alternate Phone _____

Signed _____ Date _____

Fredericksburg Implant & Oral Surgery Associates

CHART # _____

HEALTH QUESTIONAIRRE

Patient Name _____ **Date of Birth** _____ **Age** _____

Height _____ Weight_____

Have you had food or drink today? Yes No

Date of last physical exam: _____

Are you under the care of a physician? Yes No

If so, what condition is being treated? _____

_____

Name and phone # of physician _____

_____

Have you had any of the following?	**Yes**	**No**
AIDS/HIV	____	____
Allergies	____	____
Anemia	____	____
Arthritis	____	____
Artificial Joint Replacement	____	____
Asthma	____	____
Cancer	____	____
Chest Pain	____	____
Covid/Covid Vaccine	____	____
Diabetes	____	____
Emphysema	____	____
Epilepsy	____	____
Fainting	____	____
Heart Disease	____	____
Hepatitis	____	____
High Blood Pressure	____	____
Kidney Disease	____	____
Liver Disease	____	____
Lung Disease	____	____
Stroke	____	____
Thyroid Disease	____	____
Tuberculosis	____	____

Other _____

I have completed this health form to the best of my knowledge and have advised the doctor of all medical problems of which I am aware.

Signed_____

Date _____

Do you smoke? _____ How much/day? _____

Do you drink alcohol? _____ How many per week? _____

Recreational Drug Use? _____

Have you had any serious illness, operation, or been hospitalized?

If yes, for what? When?_____

_____

Have you had abnormal bleeding with prior surgery or trauma?

Yes No

Do you bruise easily? Yes No

Have you had a blood transfusion? Yes No

If yes, explain _____

Have you had surgery or radiation of a tumor, growth or other condition in your mouth and lips:

Yes No

Please list medications:

_____

_____

_____

_____

Allergies to medications:

_____

_____

Allergic or reacted adversely to:

Latex	Yes	No
Iodine	Yes	No
Local anesthetic	Yes	No
Sedatives or general anesthetics	Yes	No

Adverse reaction to dental treatment? If so, explain _____

_____

Adverse reaction to medical treatment? If so, explain _____

_____

Are you pregnant? Yes No

Nursing? Yes No

I have reviewed the health information above.

Doctor Signature _____

Date _____