VALLEY ORAL & MAXILLOFACIAL SURGERY

PATIENT'S NAME:	Circle one: Single Married Widow Divorced	DATE OF BIRTH:	AGE:	MALE FEMALE	CELL PHONE: ALTERNATE PHONE:
Mailing Address:	City & State:				Zip Code:
Employer:	Occupation:				Social Security Number:
Person Responsible for Account:	Phone number:				Relationship to Patient:
NAME OF FAMILY DOCTOR:	NAME OF DENTIST:				REFERRED BY:

IS CONDITION RELATED TO AN ACCIDENT? YES/NO DATE OF ACCIDENT: REASON FOR VISIT:
IF YES, PLEASE DESCRIBE:

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:	**YES**	**NO**	**ARE YOU USING OR TAKING ANY OF THE FOLLOWING?**	**YES**	**NO**
Are you in good health?			**Bisphosphonates?**		
Has there been any change in your general health in the past year?			**Depression**/ Anxiety Medications?		
Date of last physical exam:			Antibiotics or Sulfa Drugs?		
Are you NOW under a physician's care for a particular problem?			Anticoagulants (blood thinners)?		
Have you been hospitalized?			High blood pressure medicine?		
Have you ever had IV or General Anesthesia?			Steroids?		
Have you had any adverse effects for dental treatment?			Osteoporosis meds/ injections?		
DO YOU HAVE OR HAVE YOU EVER HAD:			Insulin, diabetes or similar drug?		
Rheumatic fever or Rheumatic heart disease?			Digitals, Inderal, Nitroglycerin, Calcium Channel Blockers, Procardia?		
Heart disease?			Marijuana or other "Street drugs"		
Lung disease ,COPD , Asthma, Tuberculosis			Antihistamines or decongestants?		
Seizures, Convulsions, epilepsy, fainting, dizziness?			**Aspirin, Ibuprofen, Motrin, Naprosyn , etc.**		
Bleeding disorder, Anemia, blood transfusion, do you bruise easily?			**Are you ALLERGIC or HAD A BAD reaction to:**		
Liver Disease?			Local Anesthetic		
Kidney Disease?			Penicillin, amoxicillin or other antibiotics?		
Diabetes?			Barbiturates, Sedatives, etc.?		
Thyroid Disease? (goiter)			Aspirin or ibuprofen?		
Arthritis? **Osteoporosis?**			Codeine or other pain killers?		
Stomach ulcers or colitis?			Latex or rubber products?		
Frequent or recurring mouth sores?			Other allergies or reactions?		
Implants placed anywhere in your body?			Do you use alcohol?		
Radiation (x-ray) treatment for cancer?			Do you smoke or chew tobacco?		
Clicking or popping of jaw joint? Grinding?					
Sinus or nasal problems?			Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide?		
HIV, AIDS, ARC?			Do you have any other disease, condition not listed above that you think the doctor should know about?		

For women only: If you are using oral contraceptives it is important that you understand that antibiotics and other medications may interfere with the effectiveness of contraceptives. Therefore, you will need to use mechanical forms of birth control. Please consult with your physician for further guidance. If you are pregnant, possibly pregnant, or trying to become pregnant, anesthetics or any medication may significantly harm your developing baby. Please advise your doctor if there is a chance of you being pregnant

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE
I UNDERSTAND THIS INFORMATION NEEDS TO BE UPDATED EVERY YEAR

Patient's signature (parent or legal guardian)	**DATE:**	**Doctor's Initials**	**DATE:**

PLEASE READ

Gary M Schwarz, DDS, MSD, PA
dba Valley Oral Maxillofacial Surgery

OFFICE POLICY CONCERNING PROFESSIONAL FEES AND INSURANCE

The Doctor and Staff of Valley Oral and Maxillofacial Surgery are committed to providing optimum health care for you and your family. We have the following payment options available for you:

*Cash/Personal Check *(There is a NSF Fee of $40 for all Returned Checks)*
*Care Credit
*Credit Card (Visa, Master Card, Discover and American Express)
******There will be a 3% processing fee for all credit cards.***
***Insurance:** Upon the **Initial** visit to our office, your Insurance Card and Social Security Number **MUST** be provided. If Insurance and Social Security Number are not provided you will be considered private pay and **responsible** for all services. As a courtesy we will verify and file a claim to your **Primary Dental Insurance.**
Because some *Dental* insurances require a coordination of benefits with *Medical* Insurance it is very Important that you provide both Medical and Dental Insurance information.
Valley OMS does *NOT have a* contract with any Medical Insurances.
If your **Medical Insurance is PRIMARY** you will be responsible to pay for treatment in full. We will **NOT** verify benefits with any ***Medical Insurance however a claim will be filed on your behalf. It is the responsibility of the member to contact their insurance company to verify if there is any Out of Network (OON) coverage.***
You also have the option to have us send a DENTAL pre-determination prior to any services being rendered.

Once insurance is verified with your Primary Dental Insurance, you will be given an ESTIMATE of your out-of-pocket expense prior to surgery. (An ***Estimate*** is **NOT** a guarantee of payment. If for any reason payment received from insurance is less than the estimate you will be billed and required to pay the balance. If the insurance **payment is more than the estimate** you will receive a **refund** within 30 days.)
Your Estimated Portion will be collected prior to treatment.

We do NOT provide In-office Financing

Monthly statements are sent to all patients with an account balance. A finance Charge of 1.5% is applied to all account balances 90 days and over.
Accounts are subject to being turned to collections if deliquent more than 90 days.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient, Parent, or Guardian Date

Dental **INSURANCE INFORMATION** **(*MUST BE PROVIDED UPON INITIAL VISIT*)**

Insurance Co:_____ Suscriber #:_____ Group #:_____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Fax Number: _____

Policy Holder/Subscriber: _____ Social Security Number: _____ DOB:_____

Policy Holder's Mailing Address: _____City: _____State: _____

Policy Holder's Relationship to Patient: () Self ()Spouse ()Parent ()Guardian () Other_____

I hereby authorize and direct my Insurance Co. to pay Gary M Schwarz, DDS, MSD, PA
dba. Valley Oral & Maxillofacial Surgery

_____ _____

(Signature) (Circle One) Self Spouse Parent Legal Guardian other Date

Medical **INSURANCE INFORMATION** **(*MUST BE PROVIDED UPON INITIAL VISIT*)**

Insurance Co:_____ Suscriber #:_____ Group #:_____

Address: _____ City: _____ State: ___ Zip: _____

Phone: _____ Fax Number: _____

Policy Holder/Subscriber: _____ Social Security Number: _____ DOB:_____

Policy Holder's Mailing Address: _____City: _____State: _____

Policy Holder's Relationship to Patient: () Self ()Spouse ()Parent ()Guardian () Other_____

I hereby authorize and direct my Insurance Co. to pay Gary M Schwarz, DDS, MSD, PA
dba. Valley Oral & Maxillofacial Surgery

_____ _____

(Signature) (Circle One) Self Spouse Parent Legal Guardian other Date

RESPONSIBLE PARTY BILLING INFORMATION (*MUST BE PRESENT*)

Relationship to patient: ()Self ()Spouse ()Parent ()Legal Guardian ()Other_____

Name: _____ Social Security Number: _____ DOB:_____

Address: _____ City_____ State____ Zip _____

Home Phone: _____ Cellular Phone: _____ Work Phone: _____

In Case of Emergency : _____ Relationship: _____ Phone: _____

Employer: _____ Business Phone Number: _____

I understand the information I have provided on this form is essential. I understand that if any changes occur I will contact the office at once. I **authorize** the release of any information pertinent to the patient care to the insurance company. I **authorize** the doctor to initiate a complaint to the Insurance Commissioner if necessary. I have read, answered and understand these questions and the information is true and correct.

_____ _____

(Signature) (Circle One) Self Spouse Parent Legal Guardian other Date

Valley Oral & Maxillofacial Surgery

Permission for Disclosure of Information

1.) **IS THERE ANYONE TO WHOM YOU WOULD GIVE PERMISSION FOR US TO DISCLOSE YOUR ACCOUNT INFORMATION?**

1.) ***¿Hay alguien a quien le daría permiso para que podamos revelar su información de su cuenta?***

Name: _____ Relationship: _____

DOB: _____ Ph #: _____

Name: _____ Relationship: _____

DOB: _____ Ph#: _____

2.) **IS THERE ANYONE TO WHOM YOU WOULD GIVE PERMISSION FOR US TO DISCLOSE YOUR DIAGNOSIS, THE PROGRESS OF YOUR SURGICAL PROCEDURE AND APPOINTMENTS?**

2.) ***¿Hay alguien a quien le da permiso para que nosotros podamos revelar su diagnóstico, el progreso de su procedimiento quirúrgico y las citas?***

Name: _____ Relationship: _____

DOB: _____ Ph #: _____

Name: _____ Relationship: _____

DOB: _____ Ph#: _____

_____ **I DO NOT WISH TO GIVE PERMISSION TO DISCLOSE MY INFORMATION TO ANYONE OTHER THAN MY INSURANCE COMPANY, REFERRING DENTIST OR PHYSICIAN.**

_____ ***No deseo dar permiso para divulgar mi información a nadie más que mi compañía de seguros , el dentista referiendose o médico .***

Signature _____ Date _____

Consent for Photography

Valley OMS

Patient Name:_____ **DOB:**_____

Parent or Legal Guardian:_____

I consent to have my (or child or an individual to whom I provide guardianship) image to be taken by staff at Valley OMS as described below.

I understand that my (or child or an individual to whom I provide guardianship) photographs, x-rays, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my bill (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that Valley OMS will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient. I understand that this information may be shared via text (**please note, this method is not encrypted**) and or via email for the purpose of continuation of care with my referring doctor or doctor I may (or child or an individual to whom I provide guardianship) be referred to by Valley OMS.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:_____

_____

_____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to written notice of withdrawal.

I release and hold harmless Valley OMS, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

Patient or Patient Representative Signature Date:

_____ _____

If Patient Representative, Relationship to the Patient Printed Name