Date:_____

# South Jersey Oral and Maxillofacial Surgeons, LLC

Patient Name:_____
First M.I. Last

Home Address_____
Street/APT

_____
City State Zip Code

Home ( )_____ Cell ( )_____ Work ( ) _____ Martial Status: ___S____M___ D____W

Date of Birth_____ Age_____ Sex ____M _____F SSN#_____

Student: _____Yes _____No ____Full Time ____Part Time

School Name:_____

Auto or Work Related Injury: _____Yes _____No

If yes, Date Of Injury:___/_____/____ Location:_____ State_____**(PIP FORM)**

**Who should we thank for referring you?**_____

Emergency Contact:_____

Phone Number:_____

Relationship:_____

## Medical Insurance Information

☐No Medical Insurance

| Primary Medical Insurance | |
|---|---|
| Insurance Co. | |
| Address | |
| Member ID/Policy Number | |
| Group Number | |
| Subscriber's Name | |
| Subscriber's Date of Birth | |
| Subscriber's SSN | |
| Relationship to Patient | |
| Employer | |

| Secondary Medical Insurance | |
|---|---|
| Insurance Co. | |
| Address | |
| Member ID/Policy Number | |
| Group Number | |
| Subscriber's Name | |
| Subscriber's Date of Birth | |
| Subscriber's SSN | |
| Relationship to Patient | |
| Employer | |

## Dental Insurance Information

☐No Dental Insurance

| Primary Dental Insurance | |
|---|---|
| Insurance Co. | |
| Address | |
| Member ID/Policy Number | |
| Group Number | |
| Subscriber's Name | |
| Subscriber's Date of Birth | |
| Subscriber's SSN | |
| Relationship to Patient | |
| Employer | |

| Secondary Dental Insurance | |
|---|---|
| Insurance Co. | |
| Address | |
| Member ID/Policy Number | |
| Group Number | |
| Subscriber's Name | |
| Subscriber's Date of Birth | |
| Subscriber's SSN | |
| Relationship to Patient | |
| Employer | |

**General Physician : _____ Phone ( ) _____ Date of Last Exam_____**

**Height: _____ Weight: _____**

| | Y | N | NOTES |
|---|---|---|---|
| **Have you ever been hospitalized for surgery or illness? If yes, please explain.** | | | |
| **Do you smoke? If yes, how much per day?** | | | |
| **Do you use or have you ever used cocaine or other illicit drugs?** | | | |
| **Do you use alcohol?** | | | |
| **Are you taking any medications (prescription & non-prescription) If yes, please list** | | | |
| **Women Only: Are you pregnant or think you may be?** | | | |
| **Are you nursing?** | | | |
| **Are you using birth control pills?** | | | |

**ARE YOU ALLERGIC TO OR EVER HAVE A REACTION TO:**

| | Y | N | NOTES | | Y | N | NOTES |
|---|---|---|---|---|---|---|---|
| **Local Anesthetics** | | | | **Penicillin** | | | |
| **Sulfa Drugs** | | | | **Aspirin** | | | |
| **Iodine** | | | | **Latex** | | | |
| **Codeine** | | | | **Other Medications** | | | |

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

| | Y | N | NOTES | | Y | N | NOTES |
|---|---|---|---|---|---|---|---|
| **High Blood Pressure** | | | | **Rheumatic Fever** | | | |
| **Heart Attack** | | | | **Thyroid Problem** | | | |
| **Heart Disease** | | | | **Anemia** | | | |
| **Heart Murmur** | | | | **Bleeding Problems** | | | |
| **Swollen Ankles** | | | | **Diabetes** | | | |
| **Pacemaker/ Valve Replacement** | | | | **Stomach Troubles/Ulcers** | | | |
| **Chest Pains** | | | | **Epilepsy/Convulsions** | | | |
| **Stroke** | | | | **Arthritis** | | | |
| **Kidney/Bladder Diseases** | | | | **Cancer** | | | |
| **AIDS/HIV Infection** | | | | **Radiation Therapy** | | | |
| **Hepatitis/Jaundice** | | | | **Liver Disease** | | | |
| **Sexually Transmitted Disease** | | | | **Psychiatric Care** | | | |
| **Joint Replacement or Implant** | | | | **Hay Fever/Allergies** | | | |
| **Asthma/Lung Problems** | | | | **Osteoporosis** | | | |
| **Emphysema** | | | | **Are you taking Fosamax, Reclast, Actonel, Boniva or Zometa?** | | | |
| **Tuberculosis** | | | | **Other** | | | |
| **Easily Winded** | | | | | | | |

**Patient Dental History**

**Dentist: _____ Phone ( ) _____ Date of Last Exam_____**

| | Y | N | NOTES |
|---|---|---|---|
| **Do you feel pain in any of your teeth?** | | | |
| **Do you have any sores or lumps in or near your mouth or neck?** | | | |
| **Have you had any head or neck injuries?** | | | |
| **Do you have frequent headaches?** | | | |
| **Do you clench or grind your teeth?** | | | |
| **Do you bite your lips or cheeks frequently?** | | | |
| **Have you ever had difficult extractions in the past?** | | | |
| **Have you had any orthodontic treatment?** | | | |
| **Have you ever had any prolonged bleeding following extractions?** | | | |
| **Have you experienced any of the following problems in your jaw?** | | | |
| **Clicking** | | | |
| **Pain** | | | |
| **Difficulty opening or closing** | | | |
| **Difficulty in chewing** | | | |

**Authorization and Release**

**I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including diagnosis and the records of any treatment of examination rendered to me during the period of such care to third party payors and/or health practitioners. I authorize & request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.**

**X_____**
**Signature of Patient or Parent of minor** **date**

**X_____**
**Signature of Treating Physician** **date**

# HIPAA/ Authorization for Release of Information

Name of Patient _____ Date of Birth _____
Phone H-_____C- _____
Email address _____

**South Jersey Oral and Maxillofacial Surgeons, LLC (SJOMS) is authorized to release protected health information referring the above named patient to the entities named below. The purpose is to obtain permission (or instructions) from the patient or guardian if minor to release specific protected health information, related appointments, and/or related financial information.**

**You should be aware that SJOMS utilizes an automated patient communication system, Lighthouse 360, exclusively for the purpose of remind/confirm appointments, and to send 2-way text or emails (periodically or as needed).**

❑ **I authorize messages (either clinical and/ or administrative in nature) to be left on my voicemail or answering machine in the event that I am unable to be reached personally.**

| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ❑ Spouse (provide name & phone number) _____ _____ | ❑ Financial<br>❑ Clinical information may include but not limited to pre-surgery details, appointment reminders |
| ❑ Parent (provide name & phone number) _____ _____ | ❑ Financial<br>❑ Clinical information may include but not limited to pre-surgery details, appointment reminders |
| ❑ Other (provide name, relationship & phone number) _____ _____ | ❑ Financial<br>❑ Clinical information may include but not limited to pre-surgery details, appointment reminders |

**Patient Information**
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 as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional upon signing this form.* This authorization shall be in effect until revoked by the patient.

**HIPAA**
I hereby acknowledge that I have been informed, read a copy or have been given a copy of the Notice of Privacy Practices.

_____**Date** _____
*Signature of Patient or if minor Parent, Guardian or Personal Representative
Description of Personal Representative's Authority: _____
*attach necessary documentation such as: Legal Guardianship Documentation or Health Care Power of Attorney

**Patient Name:**_____ **D.O.B:**_____

## South Jersey Oral and Maxillofacial Surgeons, LLC

## Insurance Financial Agreement

Our office maintains that every patient is entitled to the highest quality of oral and maxillofacial surgical care that can be provided. To avoid a misunderstanding regarding insurance, we wish for our patients to be informed that all professional services rendered are the responsibility of our patients, parents, or legal guardians. We will prepare the necessary forms to assist you in obtaining your benefits from your insurance carrier as a convenience to you. I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. **Your insurance coverage and estimated patient portion is based on verbal information provided by your insurance company, and is not a guarantee of payment.**

## AGREEMENT TO PAY

I agree to be personally responsible for the payment of all services rendered on my behalf or for all professional treatment services to the undersigned, his/her family or the patient indicated. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductible, charges denied by my insurance company as not covered or not medically necessary, and/or fees incurred should my account require collection action. (E.G. Late fees, collection agency, court or attorney costs).

In the event a quotation of fees is not given to me prior to services being performed, I shall ask for such a quotation or waive my right to later claim the fee exceeded the value of the services rendered.

**Signature Required**
The undersigned acknowledges that I have read and understand the above terms and conditions.

**Financial Responsibility** _____**Self**

Name_____ Date of Birth_____
First Last
Relation to Patient_____ Social Security #_____

Home Address_____ _____ _____
Street/Apt City Zip
Home Phone ( )_____Cell Phone ( )_____Work Phone( )_____

Employer_____ Marital Status___S___M___D____W

_____
Guarantor/Parent/Guardian completing the form (please print) Date

X_____
Guarantor/Parent/Guardian Signature Date