

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 ( ) \_\_\_\_\_ Marital 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 \_\_\_\_\_ date  
 Signature of Patient or Parent of minor

X \_\_\_\_\_ date  
 Signature of Treating Physician

# SOUTH JERSEY ORAL AND MAXILLOFACIAL SURGEONS, LLC

Laurel Professional Center 135 Jackson Road, Suite A, Medford, NJ 08055

Telephone: 609-654-1300

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## Financial Agreement

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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.

- Your insurance coverage and estimated patient portion is based on verbal information provided by your insurance company, and is not a guarantee of payment.
- You are responsible for knowing the terms and the exclusions of your policy
- To maximize your benefits, it is essential that you provide our office with accurate and complete billing information before services are rendered. If this is not achieved, we will treat it as though no coverage exists and our policies for non-insured patients will apply.

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

### ACKNOWLEDGMENT:

I acknowledge that I have read the above, understand it, and agree to the terms of this contract.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
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.**

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

## **PHARMACY INFORMATION**

Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

\*\*\*\*This will be our primary reference for your pharmacy contact information. Please let us know if this information needs to be changed or updated.\*\*\*\*