REGISTRATION

Patient_____ **PERSON RESPONSIBLE FOR ACCOUNT:**

First Middle Last **(If other than patient and here today)**

Address_____

_____**Zip**_____ **Name** _____

First Middle Last

Phone_____ **Cell Phone** _____ **Address** _____

Birthdate _____**Social Security #** _____ _____**Zip**_____

How long at this address?_____ **Phone**_____ **Birthdate**_____

If full-time student, what school?_____ **Cell Phone**_____

Employer _____ **Social Security #** _____

Position_____ **How long at this address?** _____

Employer's address _____ **Employer** _____

_____ **Zip**_____ **Position** _____

Work phone _____ **Employer's address** _____

How long at your present job? _____ _____ **Zip**_____

Spouse name _____ **Work phone** _____

Spouse Social Security # _____ **How long at your present job?** _____

Spouse employer _____

Spouse work phone _____**Spouse Birthdate** _____

DENTAL INSURANCE

Insurance Company_____ **Employee** _____

Ins. Co. Address_____ **Date of Birth** _____

_____**Zip**_____ **Employee ID #** _____

Ins. Phone Number _____ **Employee Social Security #** _____

Employer _____ **Group #** _____ **Relationship to patient** _____

I authorize release of any information relating to an insurance claim filed for services rendered to me.

Date _____ _____

Patient/Parent/Guardian

I authorize payment of the dental benefits otherwise payable to me directly to Brent Florine, DDS, PLLC.

Date _____ _____

Insurance Policy Holder

I _____**DO** _____**DO NOT have Medicare insurance coverage**

Date _____ _____

Patient/Parent/Guardian

BRENT L. FLORINE, D.D.S.
Oral and Maxillofacial Surgery

MEDICAL HISTORY

Name_____ Weight_____ lbs. Birthdate _____

1. Are you being **treated** for any condition **by a physician** now? ..... Yes No
   If yes, what condition?_____
2. Are you taking any **medications** (including birth control pills) now? ..... Yes No
   If **yes**, what are you taking? _____
3. Have you had any of the following diseases?
   Rheumatic fever ..... Yes No
   Diabetes ..... Yes No
   Heart attack (date if yes)_____ Yes No
   Chemical Dependency..... Yes No
   Stroke (date if yes) _____ Yes No
   High blood pressure ..... Yes No
   Mitral valve prolapse..... Yes No
   Other heart-related disorders ..... Yes No
   (If any, please list) _____
4. Have you ever been told by a physician that you have a **heart murmur**? ..... Yes No
5. Are you **allergic** to any drugs or materials?
   Penicillin..... Yes No
   Advil/Motrin/Ibuprofen/Codeine ..... Yes No
   Latex ..... Yes No
   Other (please list) ..... Yes No
6. Do you **bruise** easily or **bleed excessively** when you cut yourself? ..... Yes No
7. Do you ever have **chest pains** or **shortness of breath**?..... Yes No
8. Have you ever had **radiation** or **cobalt treatments** for cancer around your mouth? ..... Yes No
9. Have you ever had **hepatitis**, **liver** or **kidney trouble**? ..... Yes No
10. Do you have any **immune system disorders**?..... Yes No
11. Do you have any **blood disorders** such as anemia (thin blood?)..... Yes No
12. Do you have **asthma** or any **lung disease**? ..... Yes No
13. Do you **smoke**? If yes, number of packs/day _____ ..... Yes No
14. Have you ever had any **unusual reaction** to a **local anesthetic** (Novocain)..... Yes No
    or **general anesthetic** (Sodium Pentothal?)..... Yes No
15. Have you or any member of your family had any **muscle diseases**?..... Yes No
16. Are you **pregnant**? If yes, date due _____ ..... Yes No
17. Do you have any **artificial implants**? (joint replacement, heart valve, etc?) ..... Yes No
18. Have you ever had **<u>any</u> previous surgery**? ..... Yes No
    (If yes, type and approximate date)_____
19. Are you wearing **contact lenses**?..... Yes No
20. Time you last **ate** or **drank** anything? _____ A.M. _____ P.M. What day? _____
21. **Nearest relative** not living with you? _____ Phone _____
22. Have we treated any of your **family** or **friends**?..... Yes No
    (If yes, whom?) _____
    Referred by _____

_____ _____
Signature of Patient (or guardian if minor) Date

PAYMENT AGREEMENT

For insurance policy holders, your deductible and co-payment amounts are due on the day of service. This represents the amount that is not covered by your insurance policy. We will do our best to determine this amount prior to your care being provided. A written predetermination of benefits may also be submitted.

The co-payment made on the day of service will usually not be the exact amount of the out-of-pocket cost for your service. After your insurance payment is received, a statement will be sent to you for any amount due, payable upon receipt, or a refund will be sent if you have overpaid. Double insurance coverage does not always pay the entire balance of your bill. For this reason, we still ask for co-payment on the day of service, which will be refunded promptly if full payment is received.

If you do not have insurance, office policy requires payment in full on the day of service. You may be eligible for other payment options, but these must be arranged prior to treatment. On the day of service, a 5% discount will be granted for payment in full, by cash or check, on a balance $100.00 or more.

Payment: In consideration for our providing oral surgery services on an open account, you agree to pay all invoices within the due date stated on the invoice.

Failure to pay: If any account is unpaid ninety-one (91) days from the date of service, you understand and agree that we will impose a service charge of one and one-half percent (1.5%) per month (18% per year) or the highest amount allowed by law, whichever is lowest, on any unpaid balance. Such service charge will be imposed once in each succeeding month, with a minimum service charge of $1.00 per month on any unpaid balance.

If you do not abide by this payment agreement and our attempts to collect an account that is past due are not successful, you will be turned over to a collection agency to collect the past due amount.

Any extension of time for payments granted to you shall not constitute a waiver of any rights of our under this Payment Agreement.

I understand that I am responsible for all costs of oral surgery treatment.

Please sign this agreement if you have read and understood it, and you agree to its terms.

_____ _____

Date Person responsible for account

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy and/or have been made aware of Oral Surgery Care's Privacy Practices that are posted in the office. I understand that I may contact Oral Surgery Care at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Date Patient Signature