ORAL SURGERY ASSOCIATES OF ALASKA

www.oralsurgeryalaska.com Ray A. Holloway, D.D.S.

PATIENT INFORMATION **Date:** _____

First Name:_____ Middle Initial:_____ Last Name:_____

Sex: ☐Female ☐Male Date of Birth: _____ Age: _____ Social Security No.: _____-_____-_____ Drivers Lic. #: _____

Mailing Address:_____ City: _____ State: _____ Zip:_____

Home Tel.: (____)_____ Alt Tel.: (____)_____ Email: _____

Name of nearest relative/ friend: _____ Address: _____ Phone: (____)_____

Physician:_____ Dentist:_____ Referred By: _____

In case emergency, Please contact: First Name_____ Last Name_____ Tel.: (____)_____ Relation:_____

Who Will be responsible for your account: Relation: ☐Self ☐Spouse ☐Mother ☐Father ☐other_____

Name: _____ Soc. Sec.#: _____ Home Tel.: _____

Street:_____ City: _____ State : _____ Zip:_____

Employer: _____ Tel:(_____)_____ Email: _____

Student: ☐Full Time ☐Part Time ☐Not……..School Name and Address _____

Marital Status: ☐Married ☐Divorced ☐Legally Separated ☐ Widow ☐Single ☐Other_____

Employed: ☐Full Time ☐Part Time ☐Retired ☐Not Do you belong to a Preferred Provider Organization? ☐Yes ☐No

Primary Dental Insurance Company

Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Phone: (_____)_____

ID No.:_____

Group No ._____Group Name:_____

Insured Party (Who carries insurance , if other than patient)

Name: _____

Relation to Insured: ☐Self ☐Spouse ☐Child ☐Other

Sex: ☐F ☐M Date of Birth:_____

Street: _____

City: _____State:_____ Zip:_____

Phone: (_____)_____

S.S. No.: _____

Employer Information

Name: _____

Street: _____City:_____ State:_____ Zip:_____

Phone: (_____)_____

Primary Medical Insurance Company

Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

Phone :(_____)_____

ID No.: _____

Group No._____ Group Name: _____

Insured Party (Who carries insurance , if other than patient)

Name: _____

Relation to Insured: ☐Self ☐Spouse ☐Child ☐Other

Sex: ☐F ☐M Date of Birth:_____

Street: _____

City: _____State:_____ Zip:_____

Phone: (_____)_____

S.S. No.: _____

Employer Information

Name: _____

Street: _____City:_____ State:_____ Zip :_____

Phone: (_____)_____

(List secondary insurance on back page)

ORAL SURGERY ASSOCIATES OF ALASKA

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PATIENT INFORMATION **Date:** _____

Secondary Dental Insurance Company	**Insured Party** (Who carries insurance , if other than patient)
Name: _____ Mailing Address: _____ City:_____ State:_____ Zip:_____ Phone: (_____)_____ ID No.: _____ Group No ._____Group Name:_____	Name: _____ Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other Sex: ☐F ☐M Date of Birth:_____ Street: _____ City: _____ State:_____ Zip: _____ Phone: (_____)_____ S.S. No.: _____

Employer Information

Name: _____

Street:_____City:_____ State:_____ Zip:_____

Phone: (_____)_____

Secondary Medical Insurance Company	**Insured Party** (Who carries insurance , if other than patient)
Name: _____ Mailing Address: _____ City:_____ State:_____ Zip:_____ Phone: (_____)_____ ID No.: _____ Group No ._____Group Name:_____	Name: _____ Relation to Insured: ☐Self ☐ Spouse ☐Child ☐Other Sex: ☐F ☐M Date of Birth:_____ Street: _____ City: _____ State:_____ Zip:_____ Phone: (_____)_____ S.S. No.: _____

Employer Information

Name: _____

Street:_____City:_____ State:_____ Zip:_____

Phone: (_____)_____

HEALTH HISTORY:

Patient Name:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five year?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
37. Convulsions / epilepsy?			
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. Are you on dialysis?			
44. Swollen ankles / arthritis / joint disease?			
45. Osteoporosis / osteopenia?			
46. Osteonecrosis?			
47. Stomach ulcers?			
48. Contagious diseases?			
49. Sexually transmitted diseases?			
50. Are you immunosuppressed? Possibly from transplant surgery, etc.			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 63–66)*

		Yes	No
64.	Is there a possibility of pregnancy?	❑	❑
65.	Expected delivery date? _____		
66.	Are you nursing?	❑	❑
67.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

IS THERE A FAMILY HISTORY OF:

Patient Name:

	Yes	No
68. Cancer?	❑	❑
69. Diabetes?	❑	❑
70. Heart disease?	❑	❑
71. Anesthesia problems?	❑	❑

HAVE YOU TAKEN, OR ARE YOU NOW TAKING:	YES	NO	NOTES
72. Any kind of medication, drug, pills?			
73. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
74. Have you ever taken diet pills?			
75. Any natural product, herbal supplement or homeopathic remedy?			
76. Any bone density medications / bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva)?			
77. Tranquilizers, sleeping pills, anti-depressants, and / or narcotics on a regular basis? If so, please list:			

78. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
79. Local anesthetic (numbing meds.)?			
80. Penicillin?			
81. Other antibiotics?			
82. Sulfa drugs?			
83. Sodium pentothal / Valium / other tranquilizers?			
84. Aspirin?			
85. Amoxicillin?			
86. Codeine or other narcotics?			
87. Other medications?			
88. Latex?			
89. Soy?			
90. Eggs / yolk?			
91. Sulfites?			
92. I have no known allergies?			

93. Please list any allergies other than drug allergies:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*

X _____ **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to preform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Witness**

X _____ **Doctor**

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**

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Written Financial Policy

Thank you for choosing Oral Surgery Associates of Alaska. Our primary mission is to deliver the best and most comprehensive oral surgery care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment is **required** at the time of service. **This includes applicable coinsurance, copayments, deductibles, and any over maximum benefits.** Oral Surgery Associates accepts money orders, cashier's checks, cash, all major credit cards and Care Credit.

We bill medical or dental insurance plans as a courtesy to you. You are responsible to be sure all charges are paid whether by you or by your insurance. After 60 days, if your insurance has not responded or paid the balance on your account, you may be asked to pay the balance in full.

We do bill secondary insurance as a courtesy: however, you are responsible for supplying the proper insurance information at the time of service.

- **WE ARE A PREFERRED PROVIDER FOR SEVERAL INSURANCE COMPANIES***
  *This includes Blue Cross of Washington and Alaska, and Federal Blue Cross plans, Blue Cross plans from other states do not fall under the PPO contract * Please refer to your insurance booklet for detailed information.

  ***WE DO NOT ACCEPT MEDICARE, TRICARE, or VA**

For those patients who do not have insurance that can be billed, payment in full is due on the day of your appointment.

Unpaid accounts that become delinquent will be referred to Cornerstone Collection Agency.

If you are scheduled for surgery in the office and **NO SHOW** to your appointment or fail to call and reschedule **24 hours prior**, $150 fee will be billed to you for a failed appointment. If you are scheduled in the hospital and **NO SHOW** or fail to cancel your appointment **48 hours prior**, a $350 fee will be billed to you for lost hospital time.

If you have any questions, please do not hesitate to ask.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

Please turn over ----------→

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1-800-478-1430

HOMER
3714 Greatland Street
Homer, AK 99603
(907) 561-1430
Fax: (907) 561-2697
Toll Free: (800) 478-1430

Patient Name: _____

Patient's Consent for provider to Disclose PHI to Authorized Persons

1. **Authorization to Disclose Protected Health Information ("PHI").** I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and PHI to the persons indicated below.
2. **Persons to Whom Disclosure May be Made**. *Provider may disclose my PHI to the following persons.
   This could include referring provider office, anyone you want to make appointments on your behalf, spouse, significant other or friend

Name	Relationship, if Any
_____	_____
_____	_____
_____	_____

3. **Purpose of Disclosure.** The purpose of this disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.
4. **Expiration of Authorization**. This authorization shall continue until I revoke it in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.
5. **Conditioning of Treatment.** Provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this consent.
6. **Redisclosure by Recipient**. I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons redisclose my PHI, which may no longer be protected by federal or state law.
7. **Acknowledgement of Reading and Agreement.** I have read and understand this authorization.

_____ _____
Patient Name or Representative Date

If a Representative Signs, state the Representative's Authority:

_____