PATIENT REGISTRATION

Date: _____

Patient's Name: _____ Date of Birth: ____/____/____

SS#: _____ Sex: M F Marital Status: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

If Student, Name & Address of School: _____

Name of Spouse (& address if different): _____

Have you or any family member ever been a patient at Capitol Center for Oral Surgery? Yes No

If "yes," When? _____ Who? _____

Note: Any patient who is appointed a DPOA, Legal Guardian or is under 18 years of age MUST be accompanied by that person at all times, at all visits in this office. (DPOA's and Legal Guardians MUST have paperwork showing their status as such). _____
INITIALS

Emergency Contact: _____ Phone #: _____

Name & Address of DPOA or Legal Guardian: _____

Mother's Name & Address: _____

Mother's Employer: _____

Mother's Home #: _____ Mother's Cell #: _____ Mother's Work #: _____

Father's Name & Address: _____

Father's Employer: _____

Father's Home #: _____ Father's Cell #: _____ Father's Work #: _____

Who is responsible for your account? _____

Who is your regular Dentist? _____ Phone #: _____

Who is your regular medical Doctor? _____ Phone #: _____

Who Referred you to us? _____

May we disclose, if necessary, your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare? Yes No

Name of person: _____ *Phone #:* _____

INSURANCE COVERAGE

Patient Name: _____ **Date of Birth:** ___/___/___

PRIMARY DENTAL CARRIER

Insurance Company Name: _____

ID#: _____ Group#: _____ Effective Date: ___/___/___

Name of Subscriber: _____ Date of Birth: ___/___/___

Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer & Address: _____

SECONDARY DENTAL CARRIER

Insurance Company Name: _____

ID#: _____ Group#: _____ Effective Date: ___/___/___

Name of Subscriber: _____ Date of Birth: ___/___/___

Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer & Address: _____

PRIMARY MEDICAL CARRIER

Insurance Company Name: _____

ID#: _____ Group#: _____ Effective Date: ___/___/___

Name of Subscriber: _____ Date of Birth: ___/___/___

Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer & Address: _____

SECONDARY MEDICAL CARRIER

Insurance Company Name: _____

ID#: _____ Group#: _____ Effective Date: ___/___/___

Name of Subscriber: _____ Date of Birth: ___/___/___

Subscriber SS#: _____ Relationship to Patient: _____

Subscriber's Employer & Address: _____

***** SOCIAL SECURITY NUMBERS ARE USED TO VERIFY INSURANCE COVERAGE, IF NOT PROVIDED, PAYMENT WILL BE EXPECTED IN FULL. *****

I HAVE RECEIVED AND REVIEWED A COPY OF HIPAA Policies and Procedures. _____ _____

SIGNATURE DATE

CAPITOL CENTER
Oral & Maxillofacial Surgery, PLLC
Richard J. Rosato, D.M.D.

HEALTH HISTORY

CV_____

LUNG_____

ASA _____

MALLAMPATI CLASSIFICATION I II III IV

BMI _____

FOR OFFICE USE ONLY

Patient Name: _____ **Date of Birth**: ____/____/____

Are you in good health? Yes No Height_____ Weight _____

Are you under the care of a medical Doctor? Yes No Date of last visit: _____

Name of Doctor:_____ Phone: _____

For what were you treated: _____

Have you had any illness, operation or been hospitalized? Yes No

If so, describe: _____

Do you have any unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? Yes No

If so, describe: _____

Do you have any artificial joints, implants, heart valve replacement, vascular graft or stent? Yes No

If so, describe: _____

Do you pre-medicate with antibiotics for dental appointments? Yes No
Have you ever had local anesthesia (novocaine)? Yes No
Have you ever been put to sleep for an operation? Yes No
Do you drink alcohol? Yes No How often:_____

Do you smoke/chew tobacco? Yes No
Do you wear contact lenses? Yes No
Any adverse reaction? Yes No
Do you use recreational (street) drugs? Yes No

Have you had or do you currently have……	YES	NO	NOTES	Have you had or do you currently have……	YES	NO	NOTES
Rheumatic fever				Hepatitis			
Heart murmur				Fainting spells			
Congenital heart disease				Headaches/migraines			
High blood pressure				Epilepsy/convulsions			
Low blood pressure				Thyroid/goiter			
Chest pain/angina				Diabetes			
Heart attack				Low blood sugar			
Stroke				Kidney issues/dialysis			
Irregular heart beat				Osteoporosis			
Cardiac pacemaker				Arthritis			
Shortness of breath				HIV/Aids			
Pneumonia				Herpes			
Bronchitis/chronic cough				Cancer/Radiation/ Chemotherapy			
Emphysema				Psychiatric treatment			
Asthma				Eye disease/glaucoma			
Hay fever/sinus problems				Tumors/growths			
Anemia				Are you immunosuppressed			
Hemophilia				Delay in healing			

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) DATE SIGNATURE OF DOCTOR DATE

CAPITOL CENTER
Oral & Maxillofacial Surgery, PLLC
Richard J. Rosato, D.M.D.

HEALTH HISTORY CONTINUED

CV _____

LUNG _____

ASA _____

MALLAMPATI CLASSIFICATION I II III IV

BMI _____

FOR OFFICE USE ONLY

Patient Name: _____ **Date of Birth**: ____/____/____

MEDICATION – Are you now taking……..	YES	NO	NOTES	ALLERGIES – Are you allergic to…….	YES	NO	NOTES
Coumadin				Local Anesthetic (novocaine)			
Plavix				Penicillin/amoxicillin/augmentin			
Aspirin				Sulfa			
Vitamin E				Valium/sodium pentothal/tranquilizers			
Ginko biloba				Aspirin			
Diet pills				Codeine/narcotics			
Herbal supplements				Latex			
Aredia				Soy			
Zometa				Eggs/yolk			
Fosamax				Sulfites (preservatives)			
Actonel				Other antibiotics			
Boniva				Other medications			
Other				Other			
List ALL medications you are currently taking, including supplements not listed above:				**List ANY/ALL allergies not listed above:**			

Have you ever or are you currently taking a bisphosphonate medication (example: Boniva, Fosamax, Actonel)? Yes No

If so, describe: _____

Please describe any other medical problem or condition which may affect your treatment or you wish to discuss with the Doctor:

_____

Is there anything you wish to discuss in private with your oral surgeon? Yes No

FOR WOMEN ONLY

Are you pregnant? Yes No If yes, how many weeks/months? _____ Are you trying to get pregnant? Yes No

Are you currently breast-feeding? Yes No How many children do you have? _____

Do you wish to consult your physician to rule out pregnancy before oral surgery? Yes No

Do you understand the potential for serious adverse consequences from surgery and/or anesthesia during pregnancy, to include harm to the fetus? Yes No

Do you understand that antibiotics which might be prescribed for you may interfere with the function of birth control? In other words, an antibiotic may make the pill ineffective in preventing pregnancy. Yes No

_____ _____ _____ _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) **DATE** **SIGNATURE OF DOCTOR** **DATE**

CAPITOL CENTER
Oral & Maxillofacial Surgery, PLLC
Richard J. Rosato, D.M.D.

FINANCIAL AGREEMENT

Patient Name: _____ **Date of Birth**: ____/____/____

We are committed to providing you with the best possible care. If you have insurance, we are available to help you receive your maximum allowable remaining benefits. In order to achieve these goals we need your assistance in obtaining this goal and understanding of our financial/payment policy.

We ask that payment be made at the time service is rendered. For your convenience we accept checks, money orders, cash, debit cards, credit cards and care credit. Care Credit is a healthcare payment program that allows you payment over time and only takes a few minutes to apply at www.carecredit.com. If at any time you have questions regarding your account or treatment, please call us, we are more than happy to assist you in any way we can. Many times, a simple telephone call will clarify any questions or misunderstandings. **Cancellation Policy**, we require 48 hours notice of cancellation. If for some reason you will be unable to keep your scheduled appointment, please call us as soon as possible and at a minimum of 48 hours prior to your appointment. If you fail to meet this requirement you will be charged a $110.00 fee. This fee must be paid prior to being rescheduled with us.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Not all services are a covered benefit in all insurance contracts. Insurance companies differ in their policies regarding coverage of procedures, services that a doctor may provide and coordination with other policies you may have. They may arbitrarily select certain services they will not cover. Depending on your specific policy, (which only you are privy to all the details of), it may require you, as the subscriber, to pay nothing, a deductible, a co-pay/portion of your total costs; or it may require you to pay for the entire procedure/service.
2. We choose not to participate in managed care/PPO/HMO contracts with medical insurances or DMO contracts with dental insurances because we feel it will not allow us to provide the level of care and service that our patients and colleagues have come to expect of us and that we demand of ourselves. However, some of the medical plans allow "out of network" benefits and will reimburse all or a portion of your total out of pocket cost (depending on the details of your policy), in addition to any dental coverage you may have.
3. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. ***We must emphasize that our relationship is with you, the patient, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, you are fully responsible for all fees charged by this office regardless of your insurance coverage.*** We will do our due diligence to forward all requested information by the insurance company to receive reimbursement, however, in the event we receive denial of any/all fees after submitting all required for reimbursement, you will be responsible for any balance in full and it will be your responsibility to dispute any discrepancies you feel there are regarding reimbursement with your insurance company.

We are happy to offer pre-treatment estimates. Please be aware that this is an estimate only, based on findings during your exam and information received from your insurance company, charges may be higher or lower depending on the nature of your procedure/s. Insurance coverage estimates may also vary, being higher or lower depending on deductibles and pending claims that are processed after we review your coverage, also any other treatment you may have already received will reduce the remaining benefits allowed by your insurance contract. The first thing the insurance company states to us when we call requesting your benefits is; "the information given is not a guarantee or authorization of payment." Most insurance companies will process a claim within 4-6 weeks, if you have more than one carrier each company will take that time for processing of your claim. Any remaining balance after your insurance has paid or denied is your responsibility. Your prompt remittance is appreciated. In the event your balance is sent to collections you will also be responsible for all fees related to collecting any outstanding balance.

We appreciate the opportunity to care for you. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) **PRINTED NAME** **DATE**