Denver ORAL & MAXILLOFACIAL SURGERY

Patient Registration Forms

First Name_____ Middle Initial_____ Last Name_____
Preferred Name_____ Address_____
City, State, Zip Code_____
Home Phone_____ Cell Phone _____ Work Phone_____
Male Female Minor Single Married Domestic Partner
Birth Date_____ Social Security Number_____
Employer_____ Occupation _____
Who may we thank for referring you to our office?_____
E-mail Address_____
Preferred method of contact (circle one) E-mail Phone Text Message
Emergency Contact_____ Relationship_____ Phone_____

Responsible Party

Who is responsible for this account?_____
Name_____
Relationship to Patient_____ Birth Date_____ Driver's License Number_____
Social Security Number_____ Email Address_____
Address_____
City, State, Zip Code_____
Employer_____ Occupation_____
Method of Payment (circle one) Cash Check Credit Card

Primary Insurance Information

Name of Insured_____ Relationship to Patient_____
Insured's Birth Date_____ Insured's Social Security Number _____
Employer_____ Date Employed_____ Occupation_____
Insurance Company _____
Claims/Insurance Company Address_____
City, State, Zip Code_____
Group #_____ Subscriber ID # _____

Secondary Insurance Information

Name of Insured_____ Relationship to Patient_____
Insured's Birth Date_____ Insured's Social Security Number_____
Employer_____ Date Employed_____ Occupation_____
Insurance Company_____
Claims/Insurance Company Address_____
City, State, Zip Code_____
Group #_____ Subscriber ID #_____

Dental/Medical insurance plans do not normally provide full coverage of your dental bill. Your dental/medical coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. **Your portion of the bill will be due at the time of service.** If your insurance has not paid within 60 days from the date of service, we will look to you for prompt payment of the account.

Consent

Our office requires that all cancellations be made within a minimum of 48 hours' notice. Appointments cancelled without more than 48 business hours' notice or failed appointments (no-show), will be subject to $50.00 fee. **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents and assignees to contact me through my provided contact methods.

I understand that, due to any false information, I will be subject to criminal prosecution.

Responsible Party's Signature _____ Date_____

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

Gender: Male/Female ***Height:*** _____ ***Weight:*** _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today:

_____

Have there been any changes in your general health in the past year? Yes No
If yes, please describe:

_____

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam ____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No
If yes, why?_____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No
If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. _____	Yes	No
Prescription pain medication?	Yes	No	_____		

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.

To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

Doctors Comments: _____

_____

_____

Denver
ORAL & MAXILLOFACIAL
SURGERY

Patient Consent Form
(HIPAA) 2016

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I am authorizing you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice
- Methods of payment, including credit card information (although encrypted) will be kept safe and protected

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ , 20_____
Print Name: _____
Relationship to Patient (if signing for a minor) _____
Signature: _____

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Release of Information

Name: _____ Date: _____

_____ I authorize the release of information including but not limited to diagnosis, treatment, and financial matters. This information may be released to or discussed with the following person(s):

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

_____ I DO NOT authorize information to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

S. Matt Schacht, D.D.S., P.C offers E-mails and Text Message notifications for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. This information is only used for S. Matt Schacht, D.D.D., P.C., purposes and is governed by the same HIPAA protection as all other information. We will start utilizing this system once we have enough text/email addresses from our patients' parents/guardians.

Your Name: _____
E-Mail: _____
Mobile Number: _____

I authorize S. Matt Schacht, D.D.S., and P.C. to notify me of patient care related information using these different methods. (Please circle any that apply)

Text Messaging E-Mail Voicemail

Signature: _____ Date: _____