SHERWOOD
oral surgery

GENERAL PATIENT INFORMATION

(Mr., Mrs., Ms., Dr.) (CIRCLE ONE)	FIRST NAME	MIDDLE INITIAL	LAST NAME	NICK NAME
☐ Male ☐ Female	DATE OF BIRTH	AGE	SOC. SEC. NO.	
STREET ADDRESS		CITY	STATE	ZIP
MAILING ADDRESS		CITY	STATE	ZIP
PHONE		BUS. PHONE	CELL PHONE	
DENTIST		PHYSICIAN	REFERRED BY:	
STUDENT STATUS FULL TIME/PART TIME (CIRCLE ONE)		**MARITAL STATUS** MARRIED/DIVORCED/SINGLE/WIDOWED (CIRCLE ONE)	**EMPLOYMENT STATUS** FULL TIME/PART TIME/RETIRED/NOT (CIRCLE ONE)	

GUARANTOR AND BILLING INFORMATION *(THIS SECTION ONLY APPLIES TO MINORS)*

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT?				
SELF ☐	SPOUSE ☐	FATHER ☐	MOTHER ☐	OTHER _____
EMPLOYER NAME:		OCCUPATION:	BUS. PHONE:	
RESPONSIBLE PARTY:				
RESPONSIBLE PARTY:				
RESPONSIBLE PARTY:	ADDRESS	CITY	STATE	ZIP
IS THIS A WORKMAN'S COMP. CLAIM	YES ☐ NO ☐	IS THIS DUE TO AN ACCIDENT	YES ☐ NO ☐	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME:	POLICY/GROUP#:	SUBSCRIBER'S I.D.#:	SUBSCRIBER'S Date Of Birth:
EMPLOYER NAME:	OCCUPATION:	BUS. PHONE:	
INSURANCE MAILING ADDRESS: STREET	CITY	STATE	ZIP
TELEPHONE:	COVERAGE: MEDICAL ☐ DENTAL ☐ BOTH ☐ (check one)		

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME:	POLICY/GROUP#:	SUBSCRIBER'S I.D.#:	SUBSCRIBER'S Date Of Birth:
EMPLOYER NAME:	OCCUPATION:	BUS. PHONE:	
INSURANCE MAILING ADDRESS: STREET	CITY	STATE	ZIP
TELEPHONE:	COVERAGE: MEDICAL ☐ DENTAL ☐ BOTH ☐ (check one)		

OFFICE POLICY

We make every effort to keep down the cost of your oral surgical care, you can help us by paying upon completion of each visit. 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 substitution 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. We ask this to be paid at the time of service.

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

Signature:_____

R11/13

SHERWOOD
oral surgery

PATIENT HEALTH HISTORY

SECTION 1 GENERAL HEALTH INFORMATION

PATIENT NAME FIRST	M.I.	LAST			
IS YOUR GENERAL HEALTH GOOD? ☐ YES ☐ NO			HEIGHT	WEIGHT	AGE
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO			IF YES, STATE PHYSICIANS NAME		
DO YOU ROUTINLY TAKE OR HAVE YOU RECENTLY TAKEN ANY DRUG OR MEDICATIONS? ☐ YES ☐ NO			PLEASE LIST YOUR MEDICATIONS		
CONTINUE IF NECCESSARY					
DO YOU TAKE ANY MEDICATION FOR OSTEOPOROSIS? ☐ YES ☐ NO					
HAVE YOU EVER HAD ANY ALLERGIC REACTIONS TO DRUGS, MEDICATIONS, OR LATEX? ☐ YES ☐ NO			IF YES, PLEASE LIST		
HAVE YOU OR ANY FAMILY MEMBERS HAD A BAD ANESTHETIC EXPERIENCE? ☐ YES ☐ NO			IF YES, SPECIFY		
DO YOU NOW OR HAVE YOU HAD TROUBLE WITH YOUR JAW JOINTS? (TMJ)? ☐ YES ☐ NO			IF YES, SPECIFY		
HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? ☐ YES ☐ NO			IF YES, SPECIFY		
DO YOU SMOKE? ☐ YES ☐ NO			IF YES, HOW MUCH?		
HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH STATUS IN THE LAST YEAR? ☐ YES ☐ NO			IF YES, SPECIFY		
WOMEN: IS THERE A POSSIBILITY THAT YOU MAY BE PREGNANT? ☐ YES ☐ NO					
WOMEN: ARE YOU NURSING? ☐ YES ☐ NO					
WOMEN: DO YOU TAKE BIRTH CONTROL PILLS? ☐ YES ☐ NO					

SECTION 2 PAST MEDICAL HISTORY (MARK THE APPROPRIATE BOX INDICATING WHETHER OR NOT YOU HAVE EXPERIENCED ANY OF THE FOLLOWING)

	YES	NO		YES	NO		YES	NO
HEART DISEASE	☐	☐	ASTHMA	☐	☐	IMMUNE DEFICIENCIES	☐	☐
HEART MURMUR	☐	☐	EMPHYSEMA	☐	☐	STROKE	☐	☐
CHEST PAIN	☐	☐	BRONCHITIS	☐	☐	SEIZURE DISORDER	☐	☐
HIGH BLOOD PRESSURE	☐	☐	DIABETES	☐	☐	PSYCHIATRIC TREATMENT	☐	☐
ANEMIA	☐	☐	HEPATITIS	☐	☐	KIDNEY DISEASE	☐	☐
RHEUMATIC FEVER	☐	☐	ARTHRITIS	☐	☐	DRUG/ALCOHOL ABUSE	☐	☐
HAYFEVER/SINUS	☐	☐	STOMACH ULCERS	☐	☐	PROSTHETIC JOINTS	☐	☐
SLEEP APNEA	☐	☐	CANCER	☐	☐	HIV	☐	☐

ANY OTHER SERIOUS ILLNESS OR INJURY OR HOSPITILIZATIONS? YES ☐ NO ☐ IF YES, SPECIFY

_____

_____

_____

SECTION 3 - AUTHORIZATION (SIGNATURE OF PATIENT OR GUARDIAN IS REQUIRED BEFORE TREATMENT CAN BEGIN)
I CERTIFY THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND ABILITIES. I FURTHER MORE AUTHORIZE THIS STAFF TO UTILIZE THIS INFORMATION IN MY TREATMENT. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN ▼ _____

DATE_____

R11/13

SHERWOOD
oral surgery

Authorization for Submission of Claims, Assignment of Benefits and Release of Health Information

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 Accounting Act of 1996*** (HIPAA). I understand that by signing this consent I authorize 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);
  - ★ I authorize you to submit claims for payment for services to health care service plans or insurance companies on my behalf and in my name, and assign to you the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I an financially responsible for any charges not covered by the group insurance benefits.
  - ★ I authorize you to release to hospital or health care services plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.
- The day-to-day healthcare operations of your practice.

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.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

I authorize the release of information to the following individuals:

_____

_____

_____

_____

SHERWOOD
oral surgery

FINANCIAL AGREEMENT

We believe everyone benefits from a clear financial agreement prior to procedures being rendered. We are happy to provide you with an estimate of the expected charges prior to your surgery. We have listed below our guidelines for financial policies within our office.

Insurances will be filed as a courtesy, with estimated patient payments due at the time of service. Please keep in mind that insurance policies are a contract between you and your carrier. We will be glad to help provide appropriate documentation, but can in no way guarantee benefits.

Parents bringing a child will be deemed financially responsible. We will not bill an absent parent for charges. Any balance extending beyond 120 days with no activity will be referred to a collection agency. Any additional charges and/or court fees will be added to the account balance. Also, there will be a fee from our collection agency for returned checks.

Please be advised that if a biopsy is obtained, the specimen will be sent to an independent pathology lab. This will result in a separate charge; you will be billed directly from the lab for these services. We do not participate with medicare or medicaid.

I certify that I have read this document and agree to the terms stated.

I will be paying today with _____ cash _____ check _____ credit card _____ debit card

X_____ _____ _____

Signature | Date | Social Security #

Dentoalveolar Surgery • Dental Implant Surgery • Orthognathic Surgery • TMJ Surgery • General Anesthesia
174 Executive Dr. ▼ Suite B ▼ Danville, VA 24541
434-792-4046 ▼ FAX 434-792-7200