PATIENT INFORMATION: PLEASE PRINT AND ANSWER ALL QUESTIONS IN FULL

Title (circle) Mr. Mrs. Ms. Dr. FIRST NAME ____ MI ____ LAST NAME ____

DOB: ____ Age: ____ ☐ Female ☐ Male

Address: Street: ____

City: ____ State: ____ Zip Code: ____

Driver License #: ____ e-mail address: ____

Home Phone #: ____ Work #: ____ Cellular #: ____

Employer Name: ____ Phone number: ____ Ext. ____

Address: Street: ____

City: ____ State: ____ Zip Code: ____

☐**Spouse /** ☐**Parent Information:** Name (First Middle Initial Last): ____ ☐Father ☐Mother

Date of Birth: ____ Age: ____ Drivers License #: ____

Address: Street: ____ Apt ____

City: ____ State: ____ Zip Code: ____

Home Phone #: ____ Cellular #: ____ e-mail address: ____

Employer Name: ____ Phone number: ____ Ext. ____

Address: Street: ____

City: ____ State: ____ Zip Code: ____

Referral Information: How did you hear about us? (Name/Address): ____

Dentist: ____ Address: Street: ____ Phone: ____

City: ____ State: ____ Zip Code: ____

Physician (MD) ____ Address: Street: ____ Phone: ____

City: ____ State: ____ Zip Code: ____

In the event of an emergency, call (Name and Relation): ____

Address: Street: ____ Phone: ____

City: ____ State: ____ Zip Code: ____

Dental Insurance Information: Plan Name: ____

Policy Holder Name: ____ Policy Holder DOB: ____

Plan Address: Street: ____

City: ____ State: ____ Zip Code: ____

Plan Telephone #: ____ SSN or ID #: ____ DOB: ____

Medical Insurance Information: Plan Name: ____

Policy Holder Name: ____ Policy Holder DOB: ____

Plan Address: Street: ____

City: ____ State: ____ Zip Code: ____

Plan Telephone #: ____ SSN or ID #: ____ DOB: ____

Secondary Insurance Information (Plan Name): ____ ID #: ____

ACCIDENT OR WORK-RELATED INJURIES ONLY:

Date of Accident: ____

Attorney: ____

Address: ____

City: ____ State: ____ Zip Code: ____

Telephone #: ____

WORKMAN'S COMP ☐ Yes ☐ No

Claim #: ____

Policy Name: ____

Case Manager: ____

Telephone #: ____

HOW DO YOU INTEND TO PAY YOUR BILL TODAY?:☐VISA; ☐MASTERCARD; ☐DISCOVER; ☐CARE CREDIT; ☐CASH ; ☐OTHER

INFECTION CONTROL CHARGES: PATIENTS WHO ARE HAVING A SURGICAL PROCEDURE PERFORMED WILL BE CHARGED $50.00 TO COVER THE COSTS OF DISPOSABLES AND INFECTIOUS WASTE REMOVAL.

I, ____, ACKNOWLEDGE AND AGREE THAT I AM RESPONSIBLE FOR THE FEE CHARGED FOR SERVICES RENDERED. ANY INSURANCE COVERAGE REIMBURSEMENT WILL BE MY RESPONSIBILITY TO OBTAIN. I WILL BE PROVIDED A STATEMENT OF ANY CHARGES INCURRED AND IF I DISPUTE THE BALANCE, I WILL NOTIFY THE OFFICE, IN WRITING WITHIN FIVE DAYS OF RECEIPT OF THE STATEMENT. IF MY ACCOUNT BECOMES DELINQUENT, I AGREE TO BE SOLELY RESPONSIBLE FOR ALL RE-BILLING CHARGES, INTEREST ON THE BALANCE AT THE STATUTORY RATE OF 10 %, COLLECTION COSTS, COURT COSTS AND ATTORNEY'S FEES. IF MY CHECK IS RETURNED FOR ANY REASON, I AGREE TO PAY THE BALANCE IN FULL PLUS THE BANK SERVICE CHARGE WITHIN 10 DAYS OF RECEIPT OF NOTICE.

Signed: ____ **Witness:** ____ **Date** ____

HEALTH HISTORY: (ANSWER ALL QUESTIONS AND SIGN BELOW)

List all allergies to medicines or foods:

Allergic to Latex ❑Y ❑N

Are you taking any Medication? ❑Y ❑N. If yes, List:

Do you have any medical problems? ❑Y ❑N. If yes, List:

Have you had any operation? ❑Y ❑N. If yes, List:

In your own words, why are you here to see the doctor:

FH: Is there in your Family any history of **(Please circle)**: Diabetes, Hypertension, Cancer, stroke, Anesthesia complications, Heart Disease, Tuberculosis, Psychiatric illness, Asthma, bleeding disorders.

ROS: Have you experienced any **(Please circle)**: recent change in weight or appetite, migraines, visual changes, tinnitus, epistaxis, sore throat, shortness of breath, chronic cough, hemoptysis, dysphagia, neck masses, pain, or stiffness, angina, palpitations, nausea/vomiting.

(Please Mark)

Do you smoke? ❑Y ❑N How much?
Do you use illegal recreational drugs? ❑Y ❑N
Are you pregnant? ❑Y ❑N If yes, what month?
Do you have a living will ❑Y ❑N
Do you have a **DO NOT RESUSCITATE (DNR)** order ❑Y ❑N
Do you have fever or above normal temperature? ❑Y ❑N
Do you have a dry cough? ❑Y ❑N
Do you suffer from sinus problems? ❑Y ❑N
Do you have a runny nose ❑Y ❑N
Have you recently lost or had a reduction in your sense of smell? ❑Y ❑N
Do you have a sore throat? ❑Y ❑N
Have you been in contact with someone who has tested positive for COVID-19? ❑Y ❑N
Have you tested positive for COVID-19? ❑Y ❑N
Have you been tested for COVID-19 and are awaiting results? ❑Y ❑N
Have you traveled outside the United States by air or cruise ship in the past 14 days? ❑Y ❑N
Have you traveled within the United States by air, bus or train within the past 14 days? ❑Y ❑N
Do you have heart disease? ❑Y ❑N
Do you have a heart murmur? ❑Y ❑N
Do you have a prosthetic heart valve? ❑Y ❑N
Do you have angina? ❑Y ❑N
If yes, do you have your nitroglycerin with you? ❑Y ❑N
Have you ever had a stroke? ❑Y ❑N
Are you on any blood thinners? ❑Y ❑N
If yes, which one:
Are you taking aspirins? ❑Y ❑N If so, how many per day?
Do you have a pacemaker or implanted defibrillator? ❑Y ❑N
Have you ever had tuberculosis? ❑Y ❑N
Do you have any artificial Prosthesis? Total joint? ❑Y ❑N
Do you have arthritis? ❑Y ❑N
Do you have kidney disease? ❑Y ❑N
Have you had a kidney removed? ❑Y ❑N
Are you on dialysis? ❑Y ❑N

Do you drink? ❑Y ❑N How much?
Have you taken any diet medications in the last 5 years? ❑Y ❑N
If yes, which one:
Have you ever had an anesthesia complication? ❑Y ❑N
Do you have sleep apnea? ❑Y ❑N
Have you been hospitalized in the past 3 years? If so, explain: ❑Y ❑N
Do you have high blood pressure? ❑Y ❑N
Is your immune system compromised? ❑Y ❑N
Have you ever had a blood transfusion? ❑Y ❑N
Are you HIV positive? ❑Y ❑N
Do you have a bleeding disorder? ❑Y ❑N
Do you have diabetes? ❑Y ❑N
Do you have ❑asthma, ❑bronchitis, or ❑shortness of breath? ❑Y ❑N
Do you have any thyroid disorders? ❑Y ❑N
Do you have anemia? ❑Y ❑N
Have you ever had hepatitis? ❑Y ❑N
In the last two years, have you or are you now taking steroids? ❑Y ❑N
❑Cortisone, ❑Prednisone, ❑Dexamethasone
Do you have osteoporosis? ❑Y ❑N
Have you taken/taking/scheduled to take oral bisphosphonates?
❑Alendronate (Fosamax, Binosto) ❑Ibandronate (Boniva)
❑Bidronate, Etidronate (Didronel) ❑Risedronate (Actonel, Atelvia)
❑Tiludronate (Skelid) ❑Or any other drugs
Have you ever had cancer or a tumor? ❑Y ❑N
If so, where:
Have you ever received irradiation therapy? ❑Y ❑N
If yes, to which part of your body:
Have you ever received chemotherapy? ❑Y ❑N
If yes, what medication was used:
Have you taken/taking/scheduled to take IV bisphosphonates? ❑Y ❑N
❑Pamidronate (Aredia) ❑Zoledronic Acid (Reclast)
❑Clodronate (Bonefos) ❑Zoledronic Acid (Zometa)
❑Or any other drugs
Have you ever had any psychiatric care? ❑Y ❑N
Do you have any history of Temporomandibular Joint disease? ❑Y ❑N
Does your Temporomandibular Joint pop or click? ❑Y ❑N
If yes, which side: ☐ RIGHT ☐ LEFT ☐ BOTH

I HAVE READ THIS ENTIRE FORM AND HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY ABILITY. UPON SIGNING THIS DOCUMENT, I AGREE THAT I HAVE NOT BEEN TAKING ANY MIND-ALTERING MEDICATIONS.

Signed: Witness: Date: Reviewed By Dr.

FOR OFFICE USE ONLY

VS: BP HR Height Weight SaO_2 T°

ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER

ADVANCE NOTICE CONCERNING ANESTHESIA

Patient's name: ______________________________

Date of birth: ______________________________

Today's date: ______________________________

This form is to inform you that for your additional comfort our facilities offer additional sedations to the regular local numbing and by signing this form it is not committing you to anything. You are just acknowledging that you were informed in advance and understand the terms.

I fully understand that if I elect to receive either ☐ IV Sedation or ☐ Nitrous Oxide Sedation, it is **not** considered medically necessary and is being rendered solely for comfort. I also understand and accept that my insurance company may not cover the service provided. I also understand that any remaining balance once insurance pays will be my full responsibility due to the fact that anesthesia is not considered medically necessary.

Furthermore, I understand that Oral Facial Reconstruction and Implant Center expect payment in full up front for the anesthesia and will not accept any reductions on the fee from my insurance company.

I am aware that a $50.00 deposit will be required to schedule and hold an appointment time for IV Sedation. I also understand that this deposit is non refundable if the appointment is not cancelled and/or re-scheduled within 24 hours' notice.

____

PATIENT AND/OR GUARDIAN'S SIGNATURE

______________________________ ______________________________

PRINTED NAME DATE

ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER
AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME: ______________________________

DATE OF BIRTH: ____________________ **DATE:** ____________________

I request and authorize the doctors at the Oral Facial Reconstruction and Implant Center to release health care information of the patient named above to:

Family Member Name or Other: ______________________________

Address: ______________________________

City, State: ______________________ **Zip code:** ____________

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

Or ________ All health care information
Or ________ Other: ______________________________

____

THIS AUTHORIZATION EXPIRES ON _____________ or ________ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS ____________________

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

______________________________ ____________________

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE **DATE**

____

RELATIONSHIP TO PATIENT
(PARENT, LEGAL GUARDIAN, ETC.)

ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER
PATIENT PHOTOGRAPHY RELEASE FORM

Patient Name: ______________________________

First Middle Initial Last

Date Of Birth: **Date:**

Address: City State: Zip

I grant the Doctors at Oral Facial Reconstruction and Implant Center and any other agents, assistants or employees selected by him, permission to take and use photographs and digital images of me for the purpose of:

- ❑ **Teaching (i.e. Educational materials)**
- ❑ **Marketing (i.e. Web site, brochures, etc.)**
- ❑ **Other:** ______________________________

____

This request and authorization appliers to photography or digital images taken on:

____

Date(s) of image capture

I understand that once my photograph(s) or digital image(s) have been released, the doctors at Oral Facial Reconstruction and Implant Center and any other agents, assistants or employees selected by him may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

If this authorization has not been canceled, it will expire ______________ Days after the date signed

______________________________ ______________________________

PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE **DATE**

____

RELATIONSHIP TO PATIENT
(PARENT, LEGAL GUARDIAN, ETC.)

ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

Pursuant to statements from the Center for Disease Control (CDC) and the American Dental Association (ADA), non-essential or elective treatment, based on the assessment of our staff, will be rescheduled. According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." The ADA also recommends that urgent dental care which "focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments" be provided in as minimally invasive a manner as possible.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I further confirm I am seeking treatment for a condition that meets the emergent or urgent criteria noted above. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

____________________________ ____________________________

Signature Date

____________________________ ____________________________

Witness Date

ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER

DISCLAIMER NOTICE - FACTS YOU SHOULD KNOW ABOUT YOUR INSURANCE

By signing below, I acknowledge that I understand the following:

1. Under Florida law, physicians/dentists are generally required to carry malpractice insurance, otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Your doctor may have decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.
2. I hereby assign the doctors at Oral Facial Reconstruction and Implant Center any benefits under any policy of insurance, indemnity agreement or any other collateral source as defined in Florida statue 768.76 for any services and/or charges provided by the doctors at Oral Facial Reconstruction and Implant Center. It is the intent of the undersigned that this assignment is irrevocable and shall apply to any and all causes of actions, suits, demands, claims and counter-claims.
3. I hereby authorize my attorney to release my settlement disbursement agreement to the doctors at Oral Facial Reconstruction and Implant Center
4. Many Insurance companies require a consultation first before any treatment can be rendered.
5. Many Insurance companies require prior authorization for any kind of procedure. Some insurance companies may take 3 to 5 weeks for this process.
6. **<u>INSURANCE AUTHORIZATION</u>:** as per my medical insurance plan, I agree and request that all payments be made directly to the providers at oral facial reconstruction and implant center, for all services rendered. I also authorize the provider(s) to release to the social security administration, or intermediaries or carriers, any information needed for this claim or related Medicare claims. I also permit a copy of this authorization to be used. This authorization will also apply to all private insurance claims used by the providers. I have read and understand oral facial reconstruction and implant center's notice of privacy practices for protected health information
7. If your insurance requires a predetermination for treatment as well a full report, you will be charged $50.00 to cover mailings, duplications and telephone calls.
8. As with all insurance, there is a deductible that must be met.
9. **Dental Insurance is not meant to pay for all your dental treatment**. Many times it just helps you with your bill.
10. Many services are **<u>NOT</u>** covered by your insurances and due to the many changes in insurance policies; it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We provide you with an estimate but **<u>cannot</u>** guarantee accuracy on how much the final bill will be. We will submit your claims and will try to get the maximum benefit that your plan provides for you, but it will be **<u>your</u>** responsibility for all the charges not paid by your insurance. Therefore, we urge you, the patient, to please check with your insurance company regarding your coverage. It is **<u>your</u>** responsibility to know your individual coverage and its limitations. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company. We encourage you to read your policy to become more familiar with it. If you have any questions on how much or how often your insurance is going to pay on a procedure, you should contact your insurance company for details.
11. Once your procedure has been authorized, you will receive a phone call scheduling your surgery. Remember, your authorization is only good for a limited amount of time. Therefore you must be scheduled before the time limit expires.
12. If you are having IV sedation or general anesthesia, make sure you have nothing to eat or drink after midnight the night before your surgery, not even water.
13. **<u>Cancelled Surgical Appointments</u>** within 24 hours of notice or no shows **<u>will be charged $50.00 immediately</u>**. We understand that emergencies do occur, and we are willing to work with you. We have reserved this time **only for you** so if you need to reschedule an appointment **please** gives us a **call within 24 hours**.
14. If my records are requested by myself, I will be requested to pay the office $1.00 per copy and $25.00 per x-ray duplicate.
15. **COLLECTION COSTS CLAUSE:** I agree, That if becomes necessary to collect monies owed, I will be responsible for all cost including, but not limited to court costs, interest and attorneys' fees.

Patient's (Or Legal Guardian's) Signature	**Print Name**	**Date**
Witness	Print Name	Date