

**PATIENT INFORMATION**

**San Diego Center for Oral and Facial Surgery**

(Mr., Mrs., Ms., Dr.) First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Sex: ( ) Male ( ) Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Street: \_\_\_\_\_ Apt./Suite# \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Tel. ( ) \_\_\_\_\_ Bus. Tel. ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_  
 Driver's License# \_\_\_\_\_ Driver's Lic. State: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Primary Dentist: \_\_\_\_\_ Referred By: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**If someone else is responsible for your account, please complete:**  
 Who will be responsible (guarantor) for your account? Relation: ( ) Spouse ( ) Mother ( ) Father ( ) Other \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home Tel: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Bus. Tel: ( ) \_\_\_\_\_ Social Sec.# \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_ Driver's Lic. State: \_\_\_\_\_

In case of **EMERGENCY**, contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Tel. ( ) \_\_\_\_\_ Work Tel.( ) \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_

**College Students Age 19 and Older:** School Name: \_\_\_\_\_ Full Time / Part Time

**INSURANCE COMPANY INFORMATION (to assist in utilizing your insurance benefits, please be thorough as possible):**

	The information below is required if you do not have your insurance card(s) with you.	The information below is required if the primary subscriber is different than the guarantor above or if there is a secondary subscriber.
<b>Primary Dental Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____ START DATE OF PRIMARY INS.: _____	Primary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____
<b>Secondary Dental Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____ START DATE OF SECONDARY INS.: _____	Secondary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____
<b>Medical Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____	Primary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____

**FEES AND PAYMENTS:** We make every effort to help you manage the costs of your oral surgical care. You can assist 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. If you have any dental and/or medical insurance, we will be able to complete the proper insurance forms as a courtesy to you. 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, coinsurance, co-pays, estimated patient portion, or any other balance not paid for by your insurance carrier upon delivery of service.

This signature on file is my authorization for the release of any information necessary to process my claim. I hereby authorize payment directly to the doctor named on the insurance benefits otherwise payable to me. I agree to pay all reasonable costs and attorney's fees, if I do not pay any of the bills incurred.

**Signature of Patient or Legal Guardian Representing Patient (Guarantor):** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate YES or NO if you have or had any of the following:

YES NO	YES NO	YES NO
<input type="checkbox"/> Recent illness (within 1 year)	<input type="checkbox"/> Irregular heartbeat/palpitations	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Cough, cold or flu (recent)	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Seizures or epilepsy
<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Difficulty opening mouth / TMJ	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cirrhosis of the liver
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Blood vessel grafts	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Cortisone or steroid use	<input type="checkbox"/> HIV+ / AIDS
<input type="checkbox"/> Heart failure	<input type="checkbox"/> Extensive bleeding	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Anemia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Treatment for tumor or cancer/radiation	

Antibiotic and pain medications can alter the effectiveness of birth control pills. Use another method of birth control for the remainder of the menstrual cycle while taking antibiotics or pain medications. (If this applies to you, please initial: \_\_\_\_\_)

YES NO
<input type="checkbox"/> Are you in good health?
<input type="checkbox"/> Are you having pain or discomfort at this time?
<input type="checkbox"/> Have you had a bad experience with previous dental or surgical treatment?
<input type="checkbox"/> Have you been under the care of a physician or hospitalized during the past two years? If yes for what? _____
<input type="checkbox"/> Have you ever gone to sleep for an operation? If yes for what? _____
<input type="checkbox"/> Have you had any complications from anesthesia or previous surgery? If yes please describe: _____
<input type="checkbox"/> Have any family members had a serious reaction to a general anesthetic?
<input type="checkbox"/> Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills): _____
<input type="checkbox"/> Have you ever taken weight loss medication (e.g. FenPhen/Metabolife) or any herbal or homeopathic supplements (e.g. vitamin E)? _____
<input type="checkbox"/> Have you or do you currently take any medications for osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, Reclast, Aredia, or Zometa? _____
<input type="checkbox"/> Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs: _____
<input type="checkbox"/> Do you smoke or chew tobacco? If yes, how long? _____ If you smoke, how many packs a day? _____
<input type="checkbox"/> Are you pregnant? If yes, how many months? _____
<input type="checkbox"/> Do you wear dentures or partials?
<input type="checkbox"/> Do you wear contact lenses?

Please indicate if you have allergies of any type, including allergies to soy or soy products, milk or milk products, or latex:

YES NO	YES NO
<input type="checkbox"/> Penicillin / ampicillin / amoxicillin	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Novocain - local anesthetics - epinephrine	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> Codeine	<input type="checkbox"/> Other drugs/medications/foods/materials: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health status, or if my medications change, I will inform the doctor accordingly.

Patient's or legal guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, please indicate relationship to patient: \_\_\_\_\_

For Office Use Only

Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____
Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____



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# San Diego Center for Oral and Facial Surgery

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## Fee Agreement and Information About Insurance (Please Read Thoroughly)

Patient Name: \_\_\_\_\_

Guarantor (person financially responsible): ( ) self ( ) father ( ) mother ( ) other: \_\_\_\_\_

Your pre-treatment estimate contains information about the procedures that have been recommended to you by your doctor and the approximate costs of those procedures. The actual costs of the procedures recommended to you may be more or less depending on a variety of factors that include but are not limited to findings during surgery, materials used, and length of surgery. We make every effort to predict your surgical outcome so that your pre-treatment estimate is as accurate as possible.

Utilization of insurance benefits to cover the costs of services rendered is becoming more complicated and more difficult. It is important for patients to understand that an insurance plan is a contract between the patient and the insurance company and that payment for services rendered is ultimately the patient's responsibility. Therefore, it is very important for the patient to fully understand the rules of their insurance policy and what their insurance policy will and will not cover prior to having any procedures performed.

Because the process of utilizing insurance benefits is often a complicated task, our office will assist you in every way possible to clarify your insurance coverage and to maximize your insurance benefits. In most cases, it is impossible to determine exactly what your insurance plan will cover at the time of your consultation without a predetermination of benefits or a pre-authorization from your insurance company.

Depending on your insurance plan, we will request 20% or 35% down on the date of surgery. We will bill your insurance for the date(s) of service for the amount billed to you. Depending on your coverage, plan limitations, deductible, or use of your yearly maximum, you may or may not have a remaining balance after your insurance has paid their portion. If for any reason your insurance fails to pay their portion within 90 days, the balance due will be your responsibility. If your insurance eventually pays their portion and this leaves a credit balance on your account, you will receive the appropriate refund from our billing office. You will receive a monthly statement from our office keeping you apprised of your account status until your account is paid in full.

For patients without insurance, full payment is requested on the date of service; however, financial arrangements can be made if needed. If you do not provide us with a current and valid copy of your insurance card(s) you will be considered a cash patient and payment will be due at the time of service.

If you are a college student age 19 years or older and are claiming **full-time student status** for insurance coverage purposes, then it is your responsibility to provide our office with current student status documentation at the time of service. This documentation is necessary to process your insurance claim and can be obtained from your school's registrar's office. Our office is not responsible for any delay in payment or lack of payment from your insurance company due to the lack of student status documentation.

Many procedures performed in our office are elective in nature. These procedures include but are not limited to dental implants, bone grafts, and cosmetic and reconstructive facial surgery. Although certain elective procedures may be necessary for your overall health and well being, insurance companies, in general, offer very limited or no coverage for these types of procedures. Patients should be fully prepared to accept financial responsibility for elective type of procedures.

Our office does not accept Medicare, Medi-Cal, Denti-Cal, Blue Cross or Blue Shield insurance.

By signing below, you are indicating that you are the responsible party and the guarantor for either your account or this patient's account and that you have fully read and that you fully understand and agree to the above.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

## San Diego Center for Oral and Facial Surgery Privacy Notice

This Privacy Notice discloses the privacy practices for [www.oralurgerysandiego.com](http://www.oralurgerysandiego.com). We do not collect information on our web site. However, any information that you provide to us via e-mail will not be retained or shared with any third party unless you are or become a patient of record.

If you feel that we are not abiding by this privacy policy, you should contact us immediately via telephone at (858) 536-2900 or via e-mail at [manager@oralurgerysandiego.com](mailto:manager@oralurgerysandiego.com).

