Lisa Miller
ORAL FACIAL SURGERY

Patient Registration

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _____ M.I. _____ Last Name _____

Sex: ☐Male ☐ Female Birth Date _____ Age _____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip_____

Home Tel. _____ Cell _____ Work _____

Employer _____ Email _____

Referred By _____Dentist _____ Orthodontist _____

Medical Dr. _____ **Marital Status:** ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

In case of emergency, please contact _____ Tel. _____ Relation _____

Pharmacy Name: _____ Phone: _____

PARENT OR GUARDIAN RESPONSIBLE FOR PATIENT

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ S.S. # _____ Birthdate _____ Age _____

Home Tel. _____ Cell _____ Work _____

Employer _____ Email _____

Street _____ Apt. _____ City _____ State _____ Zip_____

Signature of Responsible Party_____

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Insurance Information

Please present your medical and dental insurance cards at your appointment. **If complete insurance information is not provided at time of service, payment will be expected in full.**

Dental Insurance

Primary Insurance Co. Name _____

Subscriber's Name (Policy Holder) _____
First Name Last Name

Address and Phone # of Insurance _____

Subscriber's Social Security # _____ Birthdate _____

Contract or ID # _____ Group # _____

Secondary Insurance Co. Name_____

Subscriber's Name (Policy Holder) _____
First Name Last Name

Address and Phone # of Insurance _____

Subscriber's Social Security # _____ Birthdate _____

Contract or ID # _____ Group # _____

Medical Insurance

Primary Insurance Co. Name_____

Subscriber's Name (Policy Holder) _____
First Name Last Name

Address and Phone # of Insurance _____

Subscriber's Social Security # _____ Birthdate _____

Contract or ID # _____ Group # _____

Secondary Insurance Co. Name_____

Subscriber's Name (Policy Holder) _____
First Name Last Name

Address and Phone # of Insurance _____

Subscriber's Social Security # _____ Birthdate _____

Contract or ID # _____ Group # _____

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Health History Form

Patient's Name _____ Date of Birth _____

Gender: _____ 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 doctor'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?_____

Have you ever had surgery? Yes No
If yes, when and what for? Date of surgery:_____ Reason for surgery:_____
Date of surgery:_____ Reason for surgery:_____

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
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	Arthritis	Yes	No
Stomach ulcers, acid reflux colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any cancer, radiation, or chemotherapy? Yes No
Describe: _____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: _____

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Health History Form

Patient's Name _____ Date of Birth _____

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	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use. _____ _____	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

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

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food allergies (nuts, eggs)?	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 or food allergies not listed above: _____

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Health History Form

Patient's Name _____ Date of Birth _____

SOCIAL HISTORY

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

Have you ever sought professional care or been hospitalized for:

Substance abuse? Yes No
Emotional disorders? Yes No
Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? _____
Marijuana? Yes No How often? _____
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

FAMILY MEDICAL HISTORY

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

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

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

I authorize Dr. Lisa Miller and team to perform an oral and maxillofacial examination for the aim of diagnosing and treatment planning. Furthermore, I authorize the taking of all x-rays needed as a necessary a part of this examination. Additionally, if medically necessary, I authorize the discharge of any data obtained within the course of my examination and treatment to my alternative doctors and/or insurance carriers.

_____ _____
Signature of patient, parent, guardian Date

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Smoking Risk

Patient Name _____ Date of Birth_____ Age _____

Please indicate your current status by initialing next to the correct statement below

_____ I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

_____ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

_____ I have smoked and stopped approximately _____ months (or) _____ years ago.

Any medical or dental surgical procedure carries an element of risk for complications and or failure. Risk factors can vary greatly from patient to patient. Smoking has been documented in the literature to delay wound healing and therefore increase the risks of complications and failure. I am aware that use of tobacco / nicotine products may increase my risk of failure and post-operative complications including but not limited to pain, swelling, infection and potential loss of implants. I acknowledge and fully understand I will be responsible for any added expenses for revisions or prolonged post-operative care.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

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Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence of the individual's office instead of the individual's home.

Cell/Home Number _____

(Please check all that apply)

- ☐ O.K to leave a detailed voice message
- ☐ Leave call back number ONLY
- ☐ O.K to send text messages
- ☐ O.K. to mail to my home address
- ☐ O.K to send an email _____

I allow you to give my clinical information to or answer questions from:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

CELL PHONE USAGE NOTICE

☐ I acknowledge that no cell phone use is allowed in consultation, surgery, and recovery areas. NO cell phone calls, photos and/or video recording. This is due to the HIPAA confidentiality regulations.

_____ _____
Print Name Date of Birth

_____ _____
Patient Signature Date

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AGREEMENT TO PAY / INSURANCE RELEASE FORM

Patient Name: _____ DOB: _____

Responsible Party Name: _____ Relationship: _____

Thank you for choosing Lisa Miller Oral Facial Surgery (hereinafter "LMOFS") as your service provider. We appreciate the opportunity to participate in your care. With respect to payment of services, please review the following policies:

• Fees are charged for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided.

• You are expected to pay any and all deductibles, copays, coinsurance amounts, and non-covered service fees. If you have a high deductible plan ($1000 or more), you are required to pay for all services in full until your deductible is met, We will bill your insurance company for all covered services.

• **Payment is required 1 week prior to your surgery to keep the reserved surgery time.** Make sure to arrange for payments to be made to our office 1 week prior or you may be removed from our schedule. If you receive notice that your appointment was removed from our schedule because it was not paid, and you feel it is an error please contact our office as soon as possible.

• You are responsible for immediately notifying LMOFS of any changes to your insurance policy and for obtaining insurance related referrals and/or authorizations in advance of your procedure.

• You are financially responsible for payment in full for any services deemed by your insurance carrier to be a non-covered service; for any service deemed by your insurance carrier to be not medically necessary; for your failure to notify us of changes in insurance coverage; or for your failure to obtain a referral or authorization as required by your insurance company.

• If payment on a claim we submit on your behalf is not received from a private insurance carrier, Medicaid, or any other third-party payer within 90 days, you are responsible for payment of your balance in full at that time. If, after we receive your payment for your service balance, your insurance company (or other third-party payer) makes a payment on your behalf, you will be issued a refund within 30 days of payment equal to the amount paid by your insurance company (or other third-party payer).

• If LMOFS is not a participating provider (out of network) with your insurance carrier, you are responsible for payment in full at the time of service. Notwithstanding, we will submit a claim to your insurance carrier on your behalf. If your insurance carrier makes a payment on your claim, you will be issued a refund check within 30 days of receipt of that insurance payment equal to the amount paid by your insurance carrier.

• You authorize LMOFS to release your patient information to third-party payers and to anyone assisting LMOFS in obtaining payment, including billing, coding, and collection agents and to the LMOFS's attorneys and consultants.

• LMOFS reserves the right to discontinue and/or refuse service(s) if you do not pay for your services.

• I understand that LMOFS cannot guarantee payment from participating insurance providers for services. Therefore, if my insurance carrier denies payment, I agree to be fully responsible for payment. **The financial obligation for dental treatment is between you and this office, not between this office and your insurance company.**

Responsible Party Signature: _____ Date: _____

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Cancellation Policy

It is our policy that you call 2 business days in advance to cancel or reschedule your appointment. Failure to give 2 business days notice could result in a $100 charge to your account. This fee will not be billed to your insurance, you will be expected to pay this before your next appointment. As a courtesy, we make multiple attempts to confirm appointments by text, email and/or phone call. It is your responsibility to notify our office of any change in contact information.

_____ _____

Sign Date