South Suburban Oral & Maxillofacial Surgeons, Ltd

Nickname: _____

Name: _____ Age: _____ Birth Date: _____
Last First M.I.

Address: _____ Weight: _____ Height: ____ Sex: ____

_____
City State Zip Code

Phone: Home # (____) _____ Work # (____) _____ Cell # (____) _____
Area Code Area Code Area Code

Patient's Dentist: _____ Pharmacy: _____

Patient's Physician: _____

Whom may we thank for referring you to our office? _____

Have you or any member of your family been a patient in this office before? ❑ Yes ❑ No

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last Physical exam: _____ Y N
4. Are you now under a physician's care for a particular problem? Y N
   If yes, for what? _____
5. Have you had any serious illnesses, operations or hospitalizations? Y N
   If yes, describe: _____
6. Have you had any adverse effects from dental treatment? Y N
7. Do you have or have you ever had any of the following:
   - Rheumatic fever or rheumatic heart disease Y N
   - Congenital heart disease Y N
   - Cardiovascular disease (heart trouble, chest pain, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker installed) Y N
   - Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, severe coughing) Y N
   - Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown Y N
   - Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily Y N
   - Liver disease (jaundice, hepatitis) Y N
   - Kidney disease Y N
   - Diabetes Y N
   - Thyroid disease Y N
   - Arthritis Y N
   - Stomach ulcers or colitis Y N
   - Glaucoma Y N
   - Implants placed in your body (heart valve, hip, knee) Y N
   - Radiation (x-ray) treatment for cancer Y N
   - Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth, grind or clench your teeth Y N

All answers are kept confidential.

   - Frequent or recurring mouth sores Y N
   - Sinus or nasal problems Y N
   - Any disease, drugs or transplant operation that may suppress your immune system Y N
     If yes, please specify: _____
     _____
   - Recurring infections of any kind Y N
8. Are you taking any medications, pills, drugs, or herbal supplements? Y N
   If yes, please specify: _____
   _____
9. Are you allergic or have a bad reaction to:
   - Local anesthesia (novocaine, etc.) Y N
   - Penicillin, amoxicillin, cephalosporins or other antibiotics Y N
   - Barbiturates, sedatives, etc. Y N
   - Aspirin or ibuprofen Y N
   - Codeine or other pain killers Y N
   - Latex or rubber products Y N
   - Other allergies or reactions Y N
   - Food Allergies: _____
10. Do you wear contact lenses? Y N
11. Do you smoke or chew tobacco? Y N
    How much daily? _____
12. Do you use alcohol or street drugs? Y N
    How much? _____
13. Have you ever sought professional care for drug abuse, or alcoholism? Y N
14. WOMEN:
    Are you pregnant or planning pregnancy? Y N
    Are you taking any birth control pills? Y N
    Are you taking hormone replacements? Y N
15. Do you have any other disease, condition or problem not listed here that you think the doctor should know about? Y N
    If yes, please specify: _____

I understand the importance of providing truthful health history to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate.

Patient/Guardian's Signature _____ Date _____

South Suburban Oral & Maxillofacial Surgeons, LTD

Patient Information

First Name | **Middle Initial** | **Last Name** | **Date of Birth** | **Age**

Marital Status
□ Single □ Married □ Life Partner □ Divorced □ Separated □ Widowed □ Other

Gender
□ Male □ Female

Home phone | **Cell Phone** | **Work phone**

Home address | **PO Box #** | **Apt #**

City | **State** | **Zip**

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed □ Active Military □ Full-time Student □ Part-time Student

Employer | **Employer phone**

Person Responsible for this Account

Relationship to Patient
□ Self (if same as patient "X" box and skip this section) □ Spouse □ Parent □ Guardian □ Other

First Name | **Middle Initial** | **Last name** | **Date of Birth**

Home phone | **Cell Phone** | **Work phone**

Home address | **PO Box #** | **Apt #**

City | **State** | **Zip**

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed □ Active Military □ Full-time Student □ Part-time Student

Employer | **Employer phone**

Insurance

Please give your insurance card(s) and picture ID to the receptionist

Dental Insurance | **ID or SS#** | **Group #**

Policy holder | **Date of Birth** | **Gender**
□ Male □ Female

Relationship to Patient
□ Self □ Spouse □ Parent □ Guardian □ Other

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed
□ Active Military □ Full-time Student □ Part-time Student

Address of insurance company | **Phone number of insurance company**

Medical Insurance | **ID or SS#** | **Group #**

Policy holder | **Date of Birth** | **Gender**
□ Male □ Female

Relationship to Patient
□ Self □ Spouse □ Parent □ Guardian □ Other

Employment status
□ Full time □ Part time □ Self-employed □ Retired □ Unemployed
□ Active Military □ Full-time Student □ Part-time Student

Address of insurance company | **Phone number of insurance company**

Please Sign Below

Assignment of Benefits: I authorize my insurance company to pay benefits directly to South Suburban Oral and Maxillofacial Surgeons for services rendered to myself or my dependents.

Date: _____ **Signature:** _____

Records Release: I authorize South Suburban Oral and Maxillofacial Surgeons to release any information, including billing and medical information to my referring doctor and insurance company.

Date: _____ **Signature:** _____

South Suburban Oral & Maxillofacial Surgeons. Ltd.

Mark T. Roszkowski, DDS, PhD
Diplomate of American Board of Oral and Maxillofacial Surgery
Fellow of American Association of Oral and Maxillofacial Surgeons

Richard T. Pihlstrom, DDS
Diplomate of American Board of Oral and Maxillofacial Surgery
Fellow of American Association of Oral and Maxillofacial Surgeons

Financial Options

Our mission is to deliver the finest, most cost effective oral surgery care available. During your evaluation the doctor will advise you of the recommended course of treatment, and our staff will discuss the cost with you. In an effort to avoid any misunderstanding we request that you read and sign this page describing your financial options.

It is the policy of the office that all fees are to be paid in full on the day of service, unless other arrangements have been made with our business office in advance. It is important that patients with insurance coverage realize that professional services are rendered to a person, not the insurance company. ***PLEASE NOTE: We are unable to quote estimated insurance benefits.The amount we request at the times of service is a deposit only.*** We strongly urge you to contact your insurance carrier to determine what your actual benefits may be, or we can submit a written pre-determination of benefits to your insurance carrier if you request it.

Patients with insurance are required to pay a deposit that reflects the ***estimated*** amounts not covered by insurance the day services are rendered. All accounts are required to be paid in full within 90 days, **regardless of insurance coverage.** If payment is subsequently made by your insurance carrier we will promptly refund any credit balance to you.

If for any reason you are unable to settle your account within 90 days, please contact our office. All account balances over 90 days will be assessed a finance charge of 1.5% per month (18% annually). Do not assume that insurance will make payment. Any account more than 90 days old is subject to being placed with a professional collection agency, and will be subject to reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency. If you have any questions regarding your account please contact our office.

Please check one of the following:

1. _____ I will pay in full at the time of service.
   Please circle one: Cash/Check Visa Mastercard Discover Amex
2. _____ I am covered by insurance and will pay all ***estimated*** "out-of-pocket" amount at the time of service. ***I understand that the amount I pay at the time of service is an estimated deposit and that I may be responsible for additional amount after insurance pays.***
3. _____ I would like to discuss the CareCredit finance option.

I HAVE READ AND UNDERSTAND THE FINANCIAL OPTIONS DESCRIBED ABOVE AND AGREE TO ABIDE BY ITS TERMS.

SIGNATURE:_____ **DATE:** _____

12-8-2017

South Suburban Oral & Maxillofacial Surgeons. Ltd.

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Fellow of American Association of Oral and Maxillofacial Surgeons

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Fellow of American Association of Oral and Maxillofacial Surgeons

DETERMINATION OF YOUR INSURANCE BENEFITS

Our office will assist you with pre-determination of benefits and estimated expenses for treatment. We will furnish sufficient documentation to assist you in obtaining information from your insurance carrier to determine your available benefits for the proposed procedures. It is important that patients with insurance coverage realize that professional services are rendered to the patient, not the insurance company. Recommended treatment is a matter to be decided between the patient and the doctor, and not based on insurance coverage.

Please contact your insurance carrier to determine the benefits available for the procedures indicated on the estimate given to you at your evaluation appointment.

When calling or contacting your insurance carrier be prepared to give them the following information:

1. Subscriber identification number and date of birth
2. Patient name and date of birth
3. Procedure codes-this is provided to you by our office on the estimate given to you at the time of your evaluation.

Please make note of the person you spoke with, and the date and time of the conversation for your records.

____ YES

____ NO

If you would prefer we will submit a written pre-determination of benefits to your **dental insurance** carrier for you. It will take approximately 2-4 weeks to receive a response from most insurance carriers. Please indicate by checking yes or no for your preference.

We will request a deposit on the day of surgery based on general coverage information we have received from your insurance carrier. This is a deposit only and does not reflect your total out of pocket expense.

I understand that it is my responsibility to determine what my insurance benefits are for any procedures provided by South Suburban Oral and Maxillofacial Surgeons, LTD. and that I am responsible for all fees regardless of insurance coverage.

Signature: _____ ***Date:*** _____

5-1-2007

402 Washington Street
Northfield, MN 55057
Phone: 507.663.6140
Fax: 507.663.7046

Main Office
Oakridge Professional Building
625 East Nicollet Blvd., Suite 205
Burnsville, MN 55337
Phone: 952.435.0310 ◆ Fax: 952.435.0311

115 1st Avenue S.E., Suite 110
New Prague, MN 56071
Phone: 952.758.2321
Fax: 952.758.2328

SOUTH SUBURBAN ORAL AND MAXILLOFACIAL SURGEONS, LTD.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Valerie Overland, Office Manager

Telephone: 952-435-0310 Fax: 952-435-0311

Address: 625 E. Nicollet Blvd. , #205 Burnsville, MN. 55337

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

****I give my consent to South Suburban Oral and Maxillofacial Surgeons to discuss my protected health information with the following person/people/family members:**

_____ **Relationship to you:** _____

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.