Patient Information

***Complete all 5 pages**

First Name:___________________________ MI:____ Last Name:_________________________________

Date of Birth:_______________ Social Security :_______-_____-________ Gender: Male ( ) Female( )

Address:____ Apt/ Suite:___________________

City:___________________________________ State:_____________ Zip Code:______________________

Phone: Home (_____)_________________________ Work(______)__________________Ext:______

Cell (_____)__________________________ Other(_____)_____________________________

Email Address:____

Employer:__________________________________ Phone(_____)______________________________

Referred by:________________________________ General Dentist:___________________________

Dental Insurance Information:

Insurance Company Name:____

ID #_________________________________Phone (____)____

Policy Holders Name- First:_____________________ MI:_________ Last Name:____________________

Relationship to patient:____

Policy Holders Social Security:_________-__________-_____________Date of Birth:________________

Primary Insurance Information:

Insurance Comp. Name:____

ID #___________________________________ Phone(_____)______________________________________

Policy Holders Name- First:_______________________ MI:_____ Last Name:_______________________

Relationship to patient: ____

Policy Holders Social Security:__________-______-________________ Date of Birth: _______________

Please provide a copy of your insurance cards and your photo ID.

Health History

Please Answer All of the Questions

1. General Health: Good ☐ Fair ☐ 2. Do you wear: contact lens ☐ glasses ☐

3. Currently under Physicians care for ____

4. List current medications, drugs, pills: ____

____

____

5. List medication allergies: ____

6. Serious illness: ____

7. List previous non-surgical hospitalizations and the reason for admission.

____

8. Previous surgery: ____

9. Previous problems with anesthesia ____

10. Have you recently used alcohol, marijuana, narcotics, sedatives, or cocaine? YES☐ NO☐

11. Any other medical illnesses or health conditions that may affect our appropriate medical care:

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:
Check if YES

- ☐ Sleep Apnea
- ☐ Seizure Disorder
- ☐ Diabetes
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Rheumatic fever
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Disease at birth
- ☐ Chest Pain
- ☐ Abnormal Bleeding
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis (Significant)
- ☐ Tuberculosis
- ☐ HIV OR AIDS
- ☐ Thyroid gland Disorder
- ☐ Kidney or Liver Disease
- ☐ Hepatitis – IF yes, Specify_______________
- ☐ Glaucoma

HAVE YOU EVER TAKEN THE FOLLOWING:
Check if YES

- ☐ Cortisone (steroids)
- ☐ Blood thinners
- ☐ Digitalis (digoxin)
- ☐ Nitroglycerin
- ☐ Radiation For cancer - Last date_________
- ☐ Bisphosphonates: Oral or IV (For your Bones)

☐ ARE YOU PREGNANT?

☐ Premed Requirement

Do you have a cold or cough? Yes☐ No☐ How long since you ate or drank anything? _________________________

Dentist ____ Physician ____

Acknowledgement of Receipt

Notice of Privacy Practice

You may refuse to sign this acknowledgement

I, ____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask questions that I may have regarding this notice.

Print Name: ____

Signature: ____

Date: ____

For Office Use

We attempted to obtain written acknowledgement of receipt of the Privacy Practice Notice.

Acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communications barriers prohibited obtaining the acknowledgment from being received.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (please specify) ____

ORAL & MAXILLOFACIAL SURGERY CENTER OF MISSISSIPPI
DR STEPHEN C. GREER II

OFFICE AND FINANCIAL POLICY

Patients without medical or dental insurance are expected to pay, prior to completion of services when rendered. We accept cash, checks, money ordered, Visa, and Master Card. If you qualify, we also accept a payment plan with Care Credit Corporation. Our staff will be happy to help you apply for a Care Credit card.

For our patients with medical and dental insurance, we will file your medical and dental claims for you. You are required to pay the full amount of the co-insurance and any applicable deductibles on the day of service, prior to service! **Please be sure to read your policy so that you understand your coverage.** Our practice is in the Delta Dental, MHP, Dentemax PPO networks. If your insurance company pays directly to you (BCBS SC State Plan, for example), we require payment in full before surgery.

If you're insurance company pays to provider, our staff will call your insurance company and obtain an **estimate** of benefits. This is not guaranteed. We will calculate the required surgery deposit based on that estimate. **There may be a balance due or overpayment after insurance payments are received.** You will be billed any balance due or we will promptly refund any overpayment to you.

It is important that you understand that we have no control over the selection of your insurance company or the benefits paid under your individual plan. As a courtesy, our staff will file your claim furnishing all the coding information necessary to adequately process your claim. Ultimately, the responsibility for payment for professional services is that of the patient.

If you have not heard from your insurance company in 60 days it is your responsibility to follow up with us. If your insurance company has not made a payment within a year the balance is also your responsibility.

Please be courteous of other patients and only bring **one person** with you on the day of surgery.

Please read all of the above and if you have any questions or concerns, please do not hesitate to contact us.

____ __________________

Signature Date

ORAL & MAXILLOFACIAL SURGERY CENTER OF MISSISSIPPI

CONSENT FOR SURGERY FORM

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to the following:

1. Swelling and/or bruising and discomfort in the surgery area.
2. Stretching of the corners of the mouth resulting in cracking or bruising.
3. Possible infection requiring additional treatment.
4. Dry Socket-jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth removal.
5. Possible damage to adjacent structures and teeth, especially those with large fillings or caps.
6. Possible complete or incomplete fracture to mandible and/or maxilla during extraction of tooth/teeth.
7. Numbness or altered sensation in the teeth, gums, lip, tongue and chin, due to the closeness of the tooth roots to the nerves (especially wisdom teeth) which can be bruised or damaged. The majority of the time, sensation returns to normal, but in rare cases, the loss may be permanent.
8. Trismus-limited joint opening due to the inflammation or swelling, most common after wisdom teeth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disorders already exists.
9. Bleeding-significant bleeding is not common, but persistent oozing can be expected for several hours.
10. Sharp ridges or bone splinters may form later at the edge of the socket. These may require another surgery to smooth or remove.
11. Incomplete removal of tooth fragments-to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.
12. Sinus involvement-the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth which may require additional care.
13. Allergic reactions to anesthesia or medication-although careful precautions are taken to obtain patient's history of allergies, certain dietary and medical factors may cause allergic reactions to anesthesia or medication used during tooth extraction.
14. Anesthetic risk include dizziness, nausea, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage, or even death.
15. ***YOUR OBLIGATIONS IF IV ANESTHESIA IS USED:***
    A. Since anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you have sufficiently recovered to care for yourself. This may take up to 24 hours.
    B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents. Etc.
    C. Prior to the procedure, you must have a completely empty stomach**. IT IS IMPORTANT THAT YOU HAVE NOTHING TO EAT OR DRINK FOR SIX (6) HOURS PRIOR TO YOUR ANESTHETIC, TO DO OTHERWISE MAY BE LIFE-THREATENING**.
    D. However, if you are taking any regular medications (e.g. high blood pressure, antibiotics, etc) it is IMPORTANT that you take these medications or any medications provided by this office, **by using only a small sip of water.**
16. OTHER____
    - I understand that individual reactions to treatment cannot be predicted, and that if I experience any un anticipated reactions during or following treatment, I agree to report them to the doctor or his designated agent as soon as possible.
    - I realize that no guarantees or assurances have been given by anyone regarding treatment results that may be obtained.
    - I also understand that if I have any questions regarding my treatment, I am to ask the doctor prior to signing this consent.
    - I hereby acknowledge that I have read the foregoing, have discussed any questions or concerns I may have regarding my proposed treatment, and that I have received a copy of this form.

Teeth to be removed____

Patient's Signature____**Date**_______________

Legal Guardian (if under 18 yrs of age)____Date_______________

Doctor's Signature__________________________________Date_______________

Witness____ Date_______________