RENO ORAL AND MAXILLOFACIAL SURGERY

Please Print Clearly

PATIENT INFORMATION

Date_____

Legal Name (First)_____ Middle Initial_____ Last_____

Preferred Name_____ Employer Name/Student Status_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Date of Birth_____ Age_____ Sex: ☐ M ☐ F SSN_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed or ☐ Minor

Referring Dentist/Doctor_____ General Dentist_____
(Circle one)

Spouse's Name_____ Date of Birth_____

☐ **Use address for Guarantor/Financially Responsible Party**

Information must be filled out completely if you wish us to bill insurance*

PRIMARY DENTAL INSURANCE

Insurance Company_____ ☐ **DENTAL** ☐ **MEDICAL**

Policy Holder's Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email Address_____

Policy Holder's SSN_____ ID #_____ Date of Birth_____

Group #_____ Employer Name_____ Occupation_____

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

SECONDARY INSURANCE

Insurance Company_____ ☐ **DENTAL** ☐ **MEDICAL**

Policy Holder's Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email Address_____

Policy Holder's SSN_____ ID #_____ Date of Birth_____

Group #_____ Employer Name_____ Occupation_____

Is patient covered by additional insurance? ☐ Yes ☐ No

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

If you have insurance: We will bill your insurance as a courtesy to you. Payment is still your responsibility. If insurance(s) does not pay within 45 days, you will be billed for the balance owed. _____(Initial)
Cash/Check or Credit: If you do not have insurance coverage, payment is due in full at time of service unless other financial arrangements have been made in advance. _____ (Initial)

EMERGENCY CONTACT

(Specify someone other than the account guarantor or insured party)

Name_____ Relationship_____

Home/Cell Phone_____ Email Address_____

☐ I authorize the dentist and/or his staff to discuss my surgical care with the above named contact _____(Initial)

ASSIGNMENT & RELEASE

I, _____certify that I, and/or my dependent(s), have insurance with_____and assign directly to Dr. Daniel F. Muff all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of my signature on all insurance submissions. _____**Initials**

Dr. Daniel F. Muff & Dr. Kimberly C. Bentjen may use my healthcare information and may disclose such information to my insurance and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I am aware that Dr. Daniel F. Muff & Dr. Kimberly C. Bentjen are HIPPA compliant and if I desire to have a printed copy of the Notice of Health Insurance Portability and Accountability Act (HIPPA), I must request a copy. _____ **Initials**

· Patients who carry dental insurance must understand that all oral surgery services furnished are charged directly to the patient and that he or she, not the insurance company, is personally responsible for payment of all oral surgery services rendered. Your insurance policy is a pre-determined arrangement between you/your employer and the insurance company. We are not a party to that contract. This office will help prepare and submit the insurance forms for our patients, assist in making collections from insurance companies, and to credit any such collections received to the patient's account. Any co-pay quoted from this office is an estimate only, not a guarantee of coverage/payment. Unfortunately, insurance benefits will almost always be less than anticipated. It is **your responsibility** to contact your insurance to determine your particular benefits or requirements. **This office cannot render services on the assumption that our charges will be paid in full by an insurance company. _____Initials**

· I understand that Dr. Daniel Muff & Dr. Kimberly C. Bentjen are **not contracted providers** with any *Medical* Insurance including Medicare. _____**Initials**

· After insurance payment is applied, I understand that should the balance be $5.00 or under, I will not be billed, or should the overpayment be $5.00 or under, I will not be refunded. _____**Initials**

· I grant my permission to this office to telephone me at home or at my workplace to discuss matters related to this form or my treatment. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my surgical care. _____**Initials**

· I understand that it is my responsibility to notify Dr. Daniel F. Muff, Dr. Kimberly C. Bentjen and staff of any medical and/or insurance changes. To the best of my knowledge, all of the information provided is correct and true. _____**Initials**

_____

(Signature of Patient/Guardian/Account Guarantor) (Date) (Relationship to Patient)

Daniel F. Muff, D.D.S., M.D.
Kimberly C. Bentjen, D.D.S., M.D.

HEALTH HISTORY

Oral and Maxillofacial Surgery

Patient's Name _____ **Date** _____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

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 _____
4. Are you now under a physician's care for a particular problem? ....Y N
5. Have you **ever** had any serious illnesses, operations, or hospitalizations? If so, please list: ....Y N
   _____
   _____
   _____
   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?....Y N
   - B. Congenital Heart Disease? ....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? ....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ....Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ....Y N
   - H. Kidney Disease? ....Y N
   - I. Diabetes? ....Y N
   - J. Thyroid Disease (Goiter)? ....Y N
   - K. Arthritis? ....Y N
   - L. Stomach Ulcers or Colitis? ....Y N
   - M. Glaucoma? ....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ....Y N
   - O. Radiation (X-ray) treatment for Cancer? ....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ....Y N
   - Q. Sinus or Nasal problems? ....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ....Y N
   - S. HIV, AIDS or ARC? ....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ....Y N
   - B. Anticoagulants (Blood Thinners)? ....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ....Y N
   - D. High Blood Pressure medications? ....Y N
   - E. Steroids (Cortisone, etc.)? ....Y N
   - F. Tranquilizers? ....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ....Y N
   - H. Intravenous Bisphophonates (Aredia, Zometa)? ....Y N
   - I. Digitalis, Nitroglycerin or other heart medications? ....Y N
   - J. Any regular prescription medicine, pills or drugs ....Y N
     If Yes, please list: _____
     _____
     _____
     _____
     _____
     _____
     _____
   - K. Herbal or Holistic remedies, Vitamins or over-the-counter medications? ....Y N
     If Yes, please list: _____
     _____
     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ....Y N
   - B. Penicillin or other antibiotics? ....Y N
   - C. Sedatives, Barbiturates? ....Y N
   - D. Aspirin or Ibuprofen? ....Y N
   - E. Codeine or other painkillers? ....Y N
   - F. Latex or Rubber Products? ....Y N
   - G. Other allergies or reactions? Please, list ....Y N
     _____
     _____
10. Do you smoke or chew Tobacco? ....Y N
    How much per day? _____
11. Do you drink alcohol? ....Y N
    How much per day? _____
12. Have you had any serious problems associated with any previous dental treatment? ....Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ....Y N
15. Do you wish to talk to the doctor privately about anything? ....Y N
16. **FEMALES ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ....Y N
    - B. Are you nursing ....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Name of Physician: _____ **Phone:** _____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ _____ _____

Date **Signature of Person Completing Health History** **Doctor's Initial**