Gulf Coast Oral & Facial Surgery

PATIENT INFORMATION:

Have you ever been a patient of our practice? ❑ Yes ❑ No
Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.____
First Name M.I. Last Name

Sex: ❑ Male ❑ Female ____
Date of Birth Age Social Security # Drivers Lic. #

____
Street Address Apt. # City State Zip

(______)__________________(______)__________________
Home Cell Email

__________________(_____)__________________
Employer Bus. Tel.

____
Referring Dentist Name Referring Orthodontist Name

__________________(______)__________________
Name of Emergency Contact Phone Relationship

Student: ❑ Full Time ❑ Part Time ❑No ____
Name of School Address

GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

❑Self (If Self, Skip this section)

REFUNDS WILL ONLY BE ISSUED TO PERSON LISTED AS RESPONSIBLE PARTY.

Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the appointment will be listed as the guarantor.

____
Last Name First Name

__________________(______)__________________
Date of Birth Social Security # Phone

____
Address of Guarantor Employer

____
City State Zip Relationship to Patient

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

AUTHORIZATION TO MAIL, CALL OR EMAIL:
I certify that I understand the privacy risks of mail, phone calls, and e-mail. I hereby authorize a Gulf Coast Oral & Facial representative or my physician to mail, call or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Gulf Coast Oral & Facial to that effect in writing.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read a copy of the Gulf Coast Oral & Facial Patient Information Privacy Policy. I hereby authorize Gulf Coast Oral & Facial or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits. I acknowledge full responsibility for the payment of all services and agree that I will take responsibility for all costs incurred by my failure to remit for services rendered.

I have read and understand **HIPAA Compliance**. **INITIAL**_______ **Signed**__________________________
A copy will be given to patient upon request. Patient, Parent or Responsible Party

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing and treatment as directed by Gulf Coast Oral & Facial Surgery.

PATIENT / GUARANTOR SIGNATURE:__________________________**DATE:**______________

Gulf Coast Oral & Facial Surgery

Failure to complete Medical and/or Dental information will result in your account being considered private pay and you will be required to pay for services in full and seek benefits from your carrier.

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE:

Employer:____

____

Ins. Co. Name:____

ID #:____

Group#:____

Address:____

Tel. (______)____

Insured Party:____

Relation:_______________________Date of Birth:_____________

Sex: ❑ Male ❑ Female

S.S.#:______________________Tel.(______)_________________

Address:____

____

SECONDARY DENTAL INSURANCE:

Employer:____

____

Ins. Co. Name:____

ID#:____

Group#:____

Address:____

Tel. (______)____

Insured Party:____

Relation:______________________________Date of Birth:____________

Sex: ❑ Male ❑ Female

S.S.#:_______________________Tel. (______)__________________

Address:____

____

MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE:

Employer:____

Plan:____

Bus. Tel. (______)_______________________________________

Ins. Co. Name:____

Address:____

____

Tel. (______)____

ID#:____

Group #:____________________Group Name:________________

Insured Party:____

Relation:_________________________Date of Birth: ____________

Sex: ❑ Male ❑ Female

S.S.#:_____________________Tel.(______)__________________

Address:____

____

SECONDARY MEDICAL INSURANCE:

Employer:____

Plan:____

Bus. Tel. (______)_______________________________________

Ins. Co. Name:____

Address:____

____

Tel. (______)____

ID#:____

Group #:__________________________Group Name:________________

Insured Party:____

Relation:______________________________Date of Birth____________

Sex: ❑ Male ❑ Female

S.S.#:___________________________Tel.(______)________________

Address:____

____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Gulf Coast Oral & Facial Surgery or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Gulf Coast Oral & Facial is unable to collect from my insurance carrier for whatever reason.

As a courtesy, we are happy to file your insurance forms. Your insurance policy is an agreement between you and your insurance company. However, if for any reason your insurance has not paid their portion within 60 days from the date of service, you will be responsible for the remaining balance. Please be aware that some procedures may not be covered under your plan.

PATIENT / GUARANTOR SIGNATURE:_________________________________**DATE:**______________

Gulf Coast Oral and Facial Surgery
Health History

1. Are you in good health? Y N Height ________ Weight ________
2. Are you now under a physician's care? Physician's name & last exam date____________________ Y N
3. Are you currently under ***pain management***? Physician's name ______________________________ Y N
4. Are you taking medication(s) including ***pain medicine*** and nonprescriptions? Y N
   List____
5. Are you currently taking ***anticoagulants/blood thinners***? List ______________________________
6. Have you had any serious illnesses, surgeries, or hospitalizations? Y N
   Explain: ____
7. Are you allergic to or had reaction to:
   - **Local anesthetic (novocaine, etc.)** Y N
   - **Antibiotics (penicillin, etc.** Y N
   - **Pain Medicine or sedatives** Y N
   - **Latex** Y N
   - **List other allergies**____ Y N
8. Do you have sleep apnea? Y N
   Do you sleep with a cpap or bipap machine? Y N
9. Have you had any adverse effects from dental treatment? Y N
10. Do you smoke, dip or chew tobacco? **If yes, how long**______________________________________ Y N
11. Have you ever sought professional care for drug abuse, alcoholism or emotional disorders? Y N
12. Have you or your family had any previous problems with anesthesia/sedation? Y N
13. Are you now or have you ever taken any of the following medications for osteoporosis?
    Oral Bisphosphonates: Fosamax, Actonel, Didronel, Boniva Y N
    IV Bisphosphonates: Aredia, Zometa, Reclast Y N
14. Have you had a previous history of temporomandibular joint disease (TMJ) ? Y N
15. Do you have or have you had: (Please check **YES** or **NO** on **EACH line.**)

	YES	NO
HEART DISEASE		
*Rheumatic Fever		
*Rheumatic Heart Disease		
*Heart Murmur		
*Mitral Valve Prolapse		
High Blood Pressure		
Angina		
Heart Attack (Coronary)		
*Heart Defects		
Stroke		
Abnormal Electrocardiogram (EKG)		
Heart Surgery		
*Pacemaker		
LUNG DISEASE	YES	NO
Bronchitis		
Asthma		

	YES	NO
LIVER DISEASE		
Hepatitis		
Cirrhosis		
DIABETES (Sugar)		
Do You Take Insulin?		
THYROID DISEASE		
GLAUCOMA		
SEIZURE DISORDER		
BLEEDING PROBLEMS		
ANEMIA		
AIDS or HIV Positive		
SICKLE CELL ANEMIA or TRAIT		
TUMOR or CANCER		
RADIATION (Cobalt) THERAPY		
*HIP JOINT SURGER		
NEUROLOGICAL DISORDER		

16. Women: Are you pregnant? Y N
    Are you taking birth control pills? Y N
    Are you taking hormone replacements? Y N
    Do you have an implanted birth control device in your upper arm? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

____/__________________

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DATE DR's. INITIALS

Gulf Coast Oral & Facial Surgery, PA

Patient Disclosure

I ______________________________ understand the HIPAA privacy rule gives individuals the
(Patient/Parent/Guardian)
right to request a restriction on uses and disclosures of their protected health information. I allow Gulf Coast Oral and Facial Surgery, PA, to give my clinical information or answers to questions regarding my care to the below individuals.

AUTHORIZED NAME & CONTACT NUMBERS

1) ____
2) ____
3) ____

Patient's Name: __________________________________
Signature: _______________________________________ Date: ______________________

Medical Consent

I, _________________________, parent/legal guardian of ____________________________
(Parent/Legal Guardian) (Patient's Name)

do hereby give consent to any medical care/treatment determined by any medical staff of Gulf Coast Oral & Facial Surgery. If the parent or legal guardian(s) are not available, I hereby authorize the names I provide below to make informed medical decisions for the health/welfare of said patient. I also understand it is MY responsibility as parent/legal guardian to provide any/all information necessary to the patient's health/welfare to the below mentioned care seekers, so that the patient receives the best care possible. This includes any proof of insurance, co-pays, and deductibles.

AUTHORIZED NAME & CONTACT NUMBERS

1) ____
2) ____
3) ____

I have read and understand/agree to all policies and procedures of Gulf Coast Oral & Facial Surgery.

Signed: ____
(Parent/Legal Guardian only)
Date: _____________________ Relationship to the patient: _____________________________

GULF COAST ORAL & FACIAL SURGERY

PRESCRIPTION NARCOTIC POLICY

Due to recent changes made by the DEA regarding narcotic prescriptions, we may only prescribe a ***3 day supply*** of narcotic pain medication.

Narcotic prescriptions must be handwritten and can no longer be phoned into a pharmacy. For this reason, we will not be able to call in prescriptions after hours or on weekends.

You are responsible for your prescriptions once you leave our office. ***LOST OR STOLEN prescriptions/medications will not be replaced.***

For patients who are currently under contract with a pain management physician: You will need to inform the pain management clinic. If you need narcotic pain medicine for your procedure, they will be responsible for prescribing your medications.

______________________________ ______________________________

Patient's Signature Date