Oral Surgeons of Southern Illinois Registration Form

Patient's Name (last, First, MI): _____ Date of Birth: _____/_____/_____

Everyone in our organization is eager to help you. We are here to assist you in navigating any oral and facial surgery needs. Our office is dedicated to you and your health.

Oral Surgeons of Southern Illinois, P.C.

Patient's Name (Last, First, MI): _____ Date of Birth: _____/_____/_____

Patient Information

Todays Date: _____ Gender: _____ Age: _____
Residence Address: _____ Home Telephone #: (_____) _____
City: _____ Zip Code: _____ Cell Telephone #: (_____) _____
Email: _____ State: _____
Occupation: _____ Employer: _____
Business Address: _____ City: _____ Tel #: (_____) _____ Ext: _____
If full time Student – School: _____ City: _____ State: _____

Insured / Responsible Party's Information

Primary Dental Ins. Co.: _____ Phone #:_____ Group #:_____
Primary Insured Name: _____ Social Security #:_____
Relationship:_____ D.O.B.: _____ Employer: _____
Secondary Dental Ins. Co.: _____Phone #:_____Group #:_____
Secondary Insured Name: _____ Social Security #: _____
Relationship: _____ D.O.B.: _____ Employer: _____
Billing Party info - Name: _____ Social Security #: _____
Residence Address: _____ Home Telephone #: (_____)_____
City: _____ State: _____ Zip Code: _____ Cell Telephone #: (_____)_____

In Case of an Emergency

Name: _____ **Relationship: _____**
Address: _____ Home Telephone #: (_____) _____
City: _____ Zip Code: _____ Cell Telephone #: (_____) _____
Employer: _____ Work Tel #: (_____) _____ Ext: _____

Primary and Referring Provider Information

Primary Care Provider: _____ **Last Office Visit: _____**
City: _____ State: _____ Telephone #: (_____) _____
Referring Dentist/Provider: _____ **Last Office Visit: _____**
City: _____ State: _____ Telephone #: (_____) _____

Has any member of your family been treated in our office (in the past)? ☐ yes ☐ no

- If yes, name and approximate date: _____

☐ **I authorize the release of any medical or dental information (notes, films, photos, etc) necessary to process this clam. I also authorize payment of any payments of any Dental or Medical Insurance Benefits to Oral Surgeons of Southern Illinois.**

☐ **I understand that I am responsible for any and all charges arising from the services delivered.**

Patient/Guardian name: _____ **Patient/Guardian Signature:_____**
Date: _____

Primary Insured name: _____ **Primary Insured Signature: _____**
Date: _____

Secondary Ins name: _____ **Secondary Ins Signature: _____**
Date: _____

Oral Surgeons of Southern Illinois, P.C.

Patient's Name (Last, First, MI): _____ Date of Birth: _____/_____/_____

Financial and Payment Policy

Payment in **FULL** is due at each appointment. If you have dental insurance, we will file your claim with your dental insurance provider. After your insurance company remits to our office, any overpayment on your account will be promptly refunded to you. If your account shows an underpayment, a statement will be sent to you. The balance will be due in 30 days. This situation is **contingent** upon the terms, eligibility, maximum benefits, deductibles, and pending claims with your dental insurance company (as adjusted from the claims filed from all your dental providers). Dental insurance is a benefit and not a guarantee of payment. As a courtesy to our patients, we will contact your insurance company before treatment to attempt to accurately advise you of your estimated dental insurance benefits. We are **NOT** responsible for misquoted or adjusted benefits due to your dental insurance company, your plan, or your dental insurance company's disclaimer.

Please remember that although we will try to assist you in every way with processing your dental insurance claim, the **contract exist between you and your dental insurance company**. The contract is not between the doctor and the dental insurance company. When you commit to treatment it must be understood that you assume **ALL** the responsibility for payment (**in full**).

Oral Surgeons of Southern Illinois reserves the right to charge a minimum of $100.00 per hour (of planned treatment, consultation, and/or surgery time) for a failed appointment, if you give less than 24 hours notice. If you are more than 15 minutes late for your appointment (consultation, evaluation, re-evaluation, and/or surgery), your appointment may be canceled and rescheduled for another day and/or time.

Accepted Methods of Payment:

1. Cash, Debit Card, or Cashier's Check - absolutely **NO PERSONAL CHECKS**
2. Visa, MasterCard, Discover, American Express,
3. Care Credit
4. FSA or HAS with visa/MasterCard logos

We do NOT offer payment plans. Estimated patient portions are collected in full at the time of service.
Interest on Unpaid Balances: You will be charged interest at 18.0% APR at 60 days from treatment/service.

☐ **I have read this page and I understand the above financial/payment policy and agree to the terms there in.**

Insured name: _____ **Patient/Guardian name: _____**

Insured Signature: _____ **Patient/Guardian Signature: _____**

Date: _____ **Date: _____**

Oral Surgeons of Southern Illinois, P.C.

Patient's Name (Last, First, MI): _____ Date of Birth: _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

You may decline to sign this authorization. Declining to sign this acknowledgement will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

- **I have received a copy of this office's Notice of Privacy Practices (if yes, please sign below).**

- **I allow you to give my clinical information to and answer questions from the following person(s) - please fill out the full name to each:**

  - **Spouse: _____**
  - **Parent: _____**
  - **Child: _____**
  - **Other: _____**

Patient Name: _____

Patient Signature: _____

Date: _____

Patient's Legal Guardian Name: _____

Patient's Legal Guardian Signature: _____

Date: _____

----------For Office use ONLY----------

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: _____

Staff: _____ Date: _____

Oral Surgeons of Southern Illinois, P.C.

Patient's Name (Last, First, MI): _____ Date of Birth: _____/_____/_____

Patient's Health History

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 check 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?

Surgery: _____	Date: _____	Dr's Name: _____
Surgery: _____	Date: _____	Dr's Name: _____
Surgery: _____	Date: _____	Dr's Name: _____
Surgery: _____	Date: _____	Dr's Name: _____

Additional: _____

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 or 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

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Glaucoma? ☐ Yes ☐ No Sleep apnea? ☐ Yes ☐ No

Diabetes? ☐ Yes ☐ No Osteoporosis or osteopenia? ☐ Yes ☐ No

Any cancer, radiation, or chemotherapy? ☐ Yes ☐ No Dr's Name: _____

Describe: _____ Date of your last treatment: _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ☐ Yes ☐ No

If yes, please explain (also please include the names and phone number of any Specialist - Cardiologist, Pulmonologist, etc):

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

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

Diabetes? ☐ Yes ☐ No Relationship: _____ Cancer? ☐ Yes ☐ No Relationship: _____

Heart disease? ☐ Yes ☐ No Relationship: _____ Bleeding problems? ☐ Yes ☐ No Relationship: _____

Tumors? ☐ Yes ☐ No Relationship: _____ Lung disease? ☐ Yes ☐ No Relationship: _____

Sleep Apnea? ☐ Yes ☐ No Relationship: _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? ☐ Yes ☐ No Weeks: _____ Trimester: _____

Are you breastfeeding? ☐ Yes ☐ No OB/Dr's Name: _____

MEDICATIONS

Are you using any of the following:

Antibiotics? ☐ Yes ☐ No

Anticoagulants (blood thinners)? ☐ Yes ☐ No

Heart medications? ☐ Yes ☐ No

Steroids (cortisone, prednisone, etc.)? ☐ Yes ☐ No

Antianxiety agents, antidepressants or other psychiatric medications? ☐ Yes ☐ No

Prescription pain medication? ☐ Yes ☐ No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐ Yes ☐ No

Insulin or oral anti-diabetic drugs? ☐ Yes ☐ No

Blood pressure 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

_____

_____

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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

Food products? ☐ Yes ☐ No

Sedatives, barbiturates? ☐ Yes ☐ No

Codeine or other pain killers? ☐ Yes ☐ No

Aspirin, Motrin, Aleve, or ibuprofen? ☐ Yes ☐ No

Penicillin or other antibiotics? ☐ Yes ☐ No

If yes, Please describe the reaction: _____

_____

Other drug or food allergies not listed above: _____

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? _____

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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? _____

Additional Information: _____

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

Patient Height (in): _____ Weight (lbs): _____

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.

_____ _____
Printed name of patient, (if under 18) parent, guardian Date

_____ __Uploaded to EMR __ XXXX signed XXXXX_____
Signature of patient, (if under 18) parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE (for Office staff only)

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

- Note, records are uploaded to the Electronic Medical Record (EMR).
- Uploaded records are reviewed in the EMR. The EMR is the official record.