MAINE ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, PA
PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Mr ☐ Mrs ☐ Ms ☐ Nickname:

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Home: _____

Soc. Sec: _____ Work: _____

Address: _____ Apt: Cell: _____

City: _____ State: _____ Zip: _____

Employer: _____ College Name & State: _____ Full time? Yes No

General Dentist: _____ Referred By: _____

Primary Care Physician:

GUARANTOR INFORMATION

*******If the patient is under 18 or is NOT financially responsible for him/herself, this section must be filled out WITH THE INFORMATION OF THE ADULT THAT CAME IN with the patient.**

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Home: _____

Soc. Sec: _____ Work: _____

Address: _____ Apt: _____ Cell: _____

City: _____ State: _____ Zip: _____

Employer: _____

Relationship to patient - The patient is my? ◯ Spouse ◯ Child Other-please specify

MEDICAL / DENTAL INSURANCE INFORMATION

Primary Insurance - please fill in with SUBSCRIBER INFORMATION: ◯ Medical or ◯ Dental

Name of Ins: _____ Subscriber ID: _____

Employer: _____ Group #: _____

Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child Other-please specify _____

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female Home: _____

Soc. Sec: _____ Work: _____

Address: _____ Apt: _____ Cell: _____

City: State: Zip:

Secondary Insurance - please fill in with SUBSCRIBER INFORMATION: ◯ Medical or ◯ Dental

Name of Ins: _____ Subscriber ID: _____

Employer: _____ Group #: _____

Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child Other-please specify _____

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Home: _____

Soc. Sec: _____ Work: _____

Address: _____ Apt: _____ Cell: _____

City: State: Zip:

I certify that the above information is correct:

Patient or Legal Guardian Signature: _____ **Date** _____

Updated 7/8/09

HEALTH QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth:_____ Sex: M F Height:_____ Weight: _____

Primary Physician: _____ Pharmacy _____

What brings you here today — Chief Complaint?_____

_____

Are you allergic to: **(Circle ALL that applies)**

☐ Latex ☐ Penicillin ☐ Tylenol ☐ Novocaine ☐ Codeine ☐ Eggs ☐ Other? _____

Are you taking: **(Circle ALL that apply)**

☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Aspirin ☐ Osteoporosis Meds (I.e. ReClast, Boniva) Other? _____

Please **LIST ALL** other medicine(s) including non-prescription you are taking (i.e. Aspirin, ibuprofen, pain killers, etc.) and/or herbal remedies (i.e. St. John's Wort, SAMe, ephedra, gingko biloba, ginseng, androstenedione) ?___

_____

Have you had any of the following? **(Circle ALL that apply)**

☐ High Blood Pressure	☐ Emphysema	☐ Dialysis	☐ Radiation Therapy
☐ Heart Attack/MI	☐ Tuberculosis	☐ Kidney Disease	☐ Treatment of Cancer
☐ Chest Pain/Angina	☐ Asthma	☐ Diabetes	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Lung Problems	☐ Thyroid Disease	☐ Artificial Joints
☐ Heart Trouble	☐ Jaundice	☐ Anemia	☐ Arthritis
☐ Heart Murmur	☐ Hepatitis A/B/C/D	☐ Transfusion	☐ Estrogen Or Steroid Meds
☐ Mitral Valve Prolapse	☐ Excessive Bleeding	☐ Seizure disorder	☐ HIV/AIDS
☐ Rheumatic Fever	☐ Liver Disease	☐ Stroke	☐ Sinusitis
☐ Shortness Of Breath	☐ Kidney Failure	☐ Ulcers/Gastric Reflux	☐ Glaucoma

Other?

_____

☐ Y ☐ N Are you required to take premedication (antibiotic) prior to any dental or surgical procedure?
Please explain_____

☐ Y ☐ N Have you or any member of your family had trouble with general anesthesia?

☐ Y ☐ N Are you on birth control?

☐ Y ☐ N Are you aware ANTIBIOTICS can make your birth control medication ineffective?

☐ Y ☐ N Is there a chance you could be pregnant?

☐ Y ☐ N If you recently had a child, are you still nursing?

☐ Y ☐ N Do you smoke? How many packs/day? How many yrs?

☐ Y ☐ N Do you drink alcohol? How often? _____#oz per day/week/month/yr

☐ Y ☐ N Do you use recreational drugs?

Are there any other medical problems or concerns that you would like to share? _____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian: _____ Date: _____

Signature of Doctor: _____ Date: _____

Maine Oral & Maxillofacial Surgery Associates, P.A.
Bruce V. Gallup, DMD Terry Wang, DMD, MD Brian L Gallagher, DMD
211 Mt. Auburn Ave
Auburn ME 04210
(207) 514-7171

Financial Policy/Privacy Practices/Benefits Authorization/Consent

Patient Name: _____

Parent/Guardian Name: _____ Date:_____

Patient, parent or guardian, please place your initials after each checked box, when you have read and fully understand the following statement(s). If you have any questions, please see a staff member.

Financial Policy: Payment for services is due in full at the time services are rendered. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit. Our office requires the use of Social Security Numbers only for account collections and to process any insurance claims on your behalf. All information is kept confidential. We respect your right to NOT provide your Social Security Number; however, if you do not provide your Social Security Number, our Office Policy requires a copy of your Drivers License or payment by "Cash Only," (no checks or credit cards), and the submission of insurance claims may be your responsibility if that is your ID number.

Insured Patients*:* Often we are required to collect a portion of our charges from some insured patients. You will be told if this situation applies to you. We will be happy to process your insurance claim if you provide us with the proper information to complete your claim. You should bring your insurance card or a completed insurance form for each office visit. Your insurance policy is a contract between you, your employer and your insurance company. We are **NOT** a party to that contract. Our relationship is with you, **not** your insurance company.

Divorced parents: We do **not** intercede with separated or divorced parents for payment. When the parents of a minor child are separated or divorced, the parent who brings the child to the office is expected to pay for care at the time services are rendered unless prior arrangements have been made with the Office Manager. Financial responsibility for care of a minor child outlined in divorce or separation agreements is independent of office policy and management.

Acknowledgement Of Receipt Of Notice Of Privacy Practices:

☒ _____ I have read/received a copy of this office's Notice of Privacy Practices.

Office Use Only: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could **not** be obtained because:

- ☐ Individual refused to sign.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify) _____.

Consent To Release Medical Information to Payors:

☒ _____ I authorize the release of any medical information necessary to process my insurance claims. In addition, I authorize direct payment to Maine Oral & Maxillofacial Surgery Associates, P.A., for any medical or dental benefits unpaid for services provided by them. I understand that any estimate given by employees of Maine Oral & Maxillofacial Surgery Associates, P.A., does not guarantee payments from insurance companies. Therefore, I understand that I am responsible for any unpaid balance.

To Our Medicaid/MaineCare Patients: This office participates in Medicaid/MaineCare. Some procedures are **not** covered under the State Of Maine Medicaid/MaineCare Program.

☐ _____ The staff at Maine Oral & Maxillofacial Surgery Associates, P.A., will notify me that, in my case, Medicaid/MaineCare is likely to **deny** payment for services provided. **If Medicaid/MaineCare denies payment, I agree to be personally and fully responsible for payment of all office charges for my care.**

To Our Medicare Patients: This office **DOES NOT** participates in Medicare, and as such we have agreed to accept Medicare approved charges. As a Medicare beneficiary, you are responsible for a deductible plus a percentage of the approved charge. Medicare might determine that a particular service is **not** covered under Medicare program standards. Medicare may thus deny payment for any of the following reasons:

1. The procedure is considered a **dental** procedure.
2. The procedure involves treatment of teeth or gums.
3. The procedure involves treatment of the supporting tissue of the teeth or gums.
4. The procedure is **not** Medicare approved (General anesthesia is **not** a covered procedure).

☐ _____ The staff at Maine Oral & Maxillofacial Surgery Associates, P.A., will notify me that, in my case, Medicare is likely to **deny** payment for services provided for the reasons noted above. **If Medicare denies payment, I agree to be personally and fully responsible for payment of all office charges for my care.**

To Our Managed Care Patients: As a member of a Managed Care Plan, you should be aware that such plans usually require your Primary Care Provider and/or Managed Care Insurance Company to provide **prior referral authorization** for specialist visits. Please take a moment to review the situations described below **and initial & place** a checkmark by the paragraph that best describes your understanding of the requirements of your plan:

☐ _____ I did **not** obtain prior authorization from my Primary Care Provider and/or Managed Care Insurance Company and am knowingly self-referring for this visit. **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ I did **not** obtain prior referral authorization from my Primary Care Provider and/or Managed care Insurance Company because I did **not** believe it was required. Or my Primary Care Provider and/or Managed Care Insurance Company informed me that a referral was **not** required. **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ My Primary Care Provider and/or Managed Care Insurance Company have agreed to refer me for this visit and it appears Maine Oral & Maxillofacial Surgery Associates, P.A. has **not** yet received the appropriate referral authorization. I understand that it is my responsibility to contact my Primary Care Provider and/or Managed Care Insurance Company immediately to confirm this referral and to obtain the authorization number for this visit. If a referral authorization number is **not** confirmed prior to consultation and/or treatment, **I understand that I will be responsible for all charges resulting from this visit.**

☐ _____ Maine Oral & Maxillofacial Surgery Associates, P.A. **has received the proper authorization** from my Primary Care Provider and/or Managed Care Insurance Company.
_____ **(Staff Member's Initials)**

I have read and understand the above statements completely.

_____
Patient/Guarantor's Signature & Date

Office Use Only:

_____
Staff Member's Initials (Reviewed by) & Date

Communication Assessment Form

Maine Oral & Maxillofacial Surgery Associates, PA
211 Mount Auburn Avenue
Auburn, ME 04210

We ask the information below so that we can communicate with patients who may be deaf, hard of hearing, or who may have a language barrier. We need to be able to communicate effectively with our patients and their companions. Communication aids and services are provided **FREE OF CHARGE.** If you require further assistance, please ask one of our staff members.

Date _____ Name of Person Requiring Assistance with Disability or Language _____

Patient's Name or Name of Person Filling out this form _____

Nature of Patient's Disability or Assistance:

- ◉ Deaf
- ○ Hard of Hearing
- ○ Speech Impairment
- ○ Interpreter for Language Help

Relationship to Patient:

- ○ Self
- ○ Family Member
- ○ Friend
- ○ Other: _____

Does the patient with a disability need/require a professional qualified sign language or oral interpreter (which will be provided free of charge) to communicate effectively with Maine Oral Surgery personnel?

- ○ No. He/she does not use sign language and does not use interpreters to lip read.
- ○ No. He/she prefers to have family members/friends help with communication. If this is the case please have the family or friend **sign the TRANSLATOR STATEMENT and AGREEMENT Form.**
- ○ No. He/she prefers writing back and forth.
- ○ Other: Explain: _____
- ○ Yes. Choose one below (free of charge).
  - American Sign Language (ASL) ☐ Signed English ☐ Oral Interpreters ☐ Language Interpreters
- ○ NO I do not need a Language Interpreter:

○ **Thank you for offering, but this does not apply to me at this time:**

Signed Patient or Guardian: _____

Employee Initials: _____

Maine Oral & Maxillofacial Surgery Associates, PA

211 Mount Auburn Avenue

Auburn, Maine 04210

HIPAA Communication Form

Date: _____Due to HIPAA laws and regulations, I _____

with my Date of Birth being _____, hereby authorize the Doctors and Staff at Maine Oral & Maxillofacial Surgery Associates, PA to discuss my treatment with the following...

Name: _____ Relationship: _____

Signed: _____

Employee Initials: _____