North Dallas Oral & Maxillofacial Surgery
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Patient Information

Welcome to our office. So that we may assist you in filing your dental insurance forms, please provide us with information requested below. All information is kept confidential.

Today's Date:_____

Patient's Name:_____
Sex:_____ Age:_____ Birth Date:_____ SS#:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____
Spouse's Name:_____

Responsible Party's Name:_____
SS#:_____ Birth Date:_____ Relation to Insured:_____
Address:_____
City:_____ State:_____ Zip:_____
Employer:_____ Occupation:_____

Name of Insurance Plan:_____
Phone #:_____ Group #:_____
Referring Dentist:_____ Physician:_____
Orthodontist:_____ Reason for Visit:_____
Family Members who have been patients here:_____

****If insurance is Medicaid, do you have additional *dental* coverage other than Medicaid? Yes No**
If Yes, please provide additional dental insurance information:
Name of insurance: _____
Phone #:_____ Member ID:_____
Group#:_____

Medical History Form

Name:_____ Date:_____
Date of Birth:_____ Sex: M/F Height:_____Weight:_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?.....Yes No
2. Has there been any change in your health in the past year?.....Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician?.....Yes No
5. The name and address of my physician is:_____
   _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No

7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?.....Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia or Zometa)?.....Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?.....Yes No
If so, please list:_____
_____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur……Yes No
    b. Rheumatic Heart Disease……..Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, or any other heart condition……Yes No
        1. Chest pain upon exertion?.....Yes No
        2. Shortness of breath after mild exercise?.....Yes No
        3. Do your ankles swell?.....Yes No
    d. Allergies……Yes No
    e. Sinus trouble……Yes No
    f. Asthma or hay fever……..Yes No
    g. Fainting spells or seizures…….Yes No
    h. Diabetes……Yes No
    i. Hepatitis, jaundice or liver disease…….Yes No
    j. Frequent or recurring mouth sores……..Yes No
    k. Thyroid problems……Yes No
    l. Respiratory problems, emphysema, bronchitis, etc…….Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ)……..Yes No
    n. Osteoporosis……....Yes No
    o. Stomach ulcer or hyperacidity……Yes No
    p. Kidney trouble……Yes No
    q. Tuberculosis……Yes No
    r. Persistent cough or cough that produces blood……Yes No
    s. Persistent swollen neck glands…….Yes No
    t. Low blood pressure…….Yes No

u. Epilepsy or neurological disorder……Yes No
v. Cancer……..Yes No
w. Any disease, drug or transplant operation that has depressed your immune system…….Yes No
x. HIV/AIDS.....Yes No

11. Have you had abnormal bleeding?.....Yes No
    a. Have you ever required a blood transfusion?.....Yes No
12. Do you have any blood disorder such as anemia?.....Yes No
13. Have you ever had treatment for a tumor or growth?.....Yes No
14. Have you had radiation therapy to the head, neck or jaws?.....Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics……Yes No
    b. Penicillin or antibiotics……Yes No
    c. Sulfa drugs……...Yes No
    d. Barbiturates or sleeping pills……...Yes No
    e. Aspirin……Yes No
    f. Iodine……Yes No
    g. Codeine or other narcotics……Yes No
    h. Latex or rubber products……..Yes No
    i. Other……Yes No
16. Have you had any serious trouble associated with previous dental treatment?.....Yes No

If so, explain:_____
_____

17. Do you have any other condition or disease you think the doctor should know about? Yes No

If so, explain:_____

18. Do you smoke or chew tobacco?.....Yes No

How much?_____

19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?.....Yes No
20. Are you wearing contact lenses?.....Yes No
21. Are you wearing removable dental appliances?.....Yes No
22. Do you wish to talk with the doctor privately about anything?.....Yes No

Women

23. Are you pregnant or trying to become pregnant?.....Yes No
24. Do you have problems associated with your menstrual period?.....Yes No
25. Are you nursing?..... Yes No
26. Are you taking birth control pills?.....Yes No

Chief Dental Complaint:_____
_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:_____ Patient's Signature:_____

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Financial Policy

Thank you for choosing North Dallas Oral & Maxillofacial Surgery. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

The payment options you can choose from are:

-Cash, Visa, Mastercard, or American Express.
-NO INTEREST Payment Plans from CareCredit.

North Dallas Oral & Maxillofacial Surgery requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.
For patients with **dental** insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Your dental insurance policy is a contract between you, your employer and the insurance company. We are **not** a party to that contract. Our involvement will be limited to supplying factual information to facilitate claim processing. All charges are your responsibility whether your insurance company pays or does not pay. Our office is out of network with all **medical** insurances. However, we will be happy to submit a claim to your medical insurance as an out-of-network provider on your behalf.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment. If you choose to take advantage of special offers provided in our office, claims will not be filed with your insurance.

If your insurance company does not pay in 30 days, it is your responsibility to contact the insurance carrier to expedite payment. If your insurance carrier does not pay in full with in 45 days, we require that you pay the balance. **If your insurance does not pay at all, you are responsible for payment.** Balances older than 60 days may be subject to collection placement and fees.

A) I authorize payment from my insurance carrier be made directly to Dr. Afshin Rezvani.
B) I authorize this office to release necessary dental information.

A fee of $75 is charged to patients who miss or cancel two or more times without a 24-hour notice.

Patients are responsible for letting the office know about **ANY** changes to their insurance company or benefits that might affect the dental or medical coverage for services provided.

Again, thank you for choosing this office for your oral surgery treatment. We appreciate your trust in us and the opportunity to serve you.

Patient, Parent or Guardian Signature Patient Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement 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)**

_____
_____
_____