Canterbury Oral & Maxillofacial Surgery

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Dear Patients,

We welcome you to our practice and are happy to have the opportunity to serve you. We take pride in our efforts to make your visit to our office a pleasant experience. Your oral health and comfort are our primary concerns.

If you are unable to keep your appointment, please contact our office as soon as possible to let us know. If you are under the age of 18, a parent or guardian must accompany you.

Please find the following Patient Information and Medical History forms. We ask that you do the following prior to your appointment:

- We ask that you **complete the forms in their entirety.** If any questions or areas do not apply, please mark with "N/A." Sign each form where necessary.
- We will need a photocopy or photo (front and back) of your insurance card(s) returned to our office with your completed information packet **within two days of receipt.** You may return the information personally or by mail, fax, or email. We need both medical and dental insurance information before confirmation of your appointment.
- We will also need a photocopy or photo of driver's license, or other government-issued photo ID, for the person financially responsible for the account.
- Our doctors are not contracted providers for Medicad or Medicare; our charges cannot be submitted to either. Patients with Medicare will be required to sign a Medicare Beneficiary Private Contract.

If you have any questions, please do not hesitate to call us at the above number.

Office hours:

Tuesday - Thursday | **8:00 - 4:30**
Friday | **8:00 - 4:00**

Sincerely,

Canterbury Oral & Maxillofacial Surgery

CANTERBURY ORAL &
MAXILLOFACIAL SURGERY

Today's Date _____

Thank you for choosing our office. We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill this form out completely. Please use ink if filling out a hardcopy. If you have any questions or need assistance, please ask, we will be happy to help. All information will be kept confidential.

Full Name _____ Age _____ Date of Birth _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Employer _____

☐ Male ☐ Female Check one: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name _____

Have you or any family members been a patient here before? If so, name _____ Year _____

PERSON FINANCIALLY RESPONSIBLE FOR THE PATIENT

Name _____ Signature of person responsible _____

Relationship to this patient _____ Date of Birth _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Employer _____ E-mail _____

INSURANCE INFORMATION

Policy Holder's Name _____ SS# _____ Date of Birth _____

Address _____ Phone # _____

Dental Insurance? ☐ Yes ☐ No Company _____ Policy # _____ Group # _____

Medical Insurance? ☐ Yes ☐ No Company _____ Policy # _____ Group # _____

ANSWER THE FOLLOWING ONLY IF A DEPENDENT

Mother's Name _____ Father's Name _____

Address _____ Address _____

Home # _____ Home # _____

Cell # _____ Cell # _____

Place of Employment _____ Place of Employment _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately and completely answered. I hereby grant permission to the doctor and staff of this office to release information including the diagonosis and the records of any treatment or examination rendered to me to assist in obtaining payment from my insurance carriers. I authorize and request my insurance company to pay directly to the doctor of this practice. I understand that my insurance carrier may pay less than the actual bill for services. **I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR TO MY DEPENDENTS AT THE TIME OF SERVICE.** I grant permission to the doctor or staff of this office to release medical information to my dentist or other medical personnal as deemed necessary in treating my current condition.

Patient, parent or guardian signature _____ Date _____

CANTERBURY ORAL &
MAXILLOFACIAL SURGERY

Today's Date _____

Patient Name _____ Date of Birth _____

Patient Height _____ Patient Weight _____

MEDICAL HISTORY

HAVE YOU HAD	YES	NO	DESCRIBE
General anesthesia/surgery	☐	☐	
Anesthesia complications (including local)	☐	☐	
Unfavorable reaction to dental treatment	☐	☐	

DO YOU HAVE OR HAVE YOU HAD PROBLEMS WITH THE FOLLOWING	YES	NO	DESCRIBE
Eyes (cataracts, glaucoma, contacts, etc.)	☐	☐	
Ears, nose, sinuses	☐	☐	
Endocrine (thyroid, diabetes)	☐	☐	
Heart (chest pain, irregular beat, MI, murmur)	☐	☐	
Vascular (aorta, carotid, DVT)	☐	☐	
High blood pressure	☐	☐	
Cholesterol	☐	☐	
Blood (bleeding, clotting, transfusion, bruising)	☐	☐	
Lungs (asthma, emphysema, TB, COPD)	☐	☐	
Intestinal (heartburn, ulcer)	☐	☐	
Liver (hepatitis)	☐	☐	
Kidneys or bladder	☐	☐	
Bones, joints, back, neck, spine	☐	☐	
Brain (stroke, TIA, Alzheimer's, seizures)	☐	☐	
Psychiatric (anxiety, depression, etc.)	☐	☐	
Skin (psoriasis, rash, etc.)	☐	☐	
Cancer	☐	☐	
Immune deficiency, contagious disease	☐	☐	
Disruptive snoring or sleep apnea	☐	☐	

Have you taken any of the following for osteoporosis or cancer treatment? ☐ **YES** ☐ **NO**

Etidronate (Disdronel) Tiluderonate (Skelid) Alendronate (Fosamax) Risedronate (Actonel/Atelvia)

Ibandronate (Boniva) Pamidronate (Aredia) Zoledronate (Zometa or Reclast) Prolia XGEVA

HAVE YOU HAD	YES	NO	DESCRIBE
Joint replacements	☐	☐	
Heart Valve surgery	☐	☐	

FEMALES	YES	NO	DESCRIBE
Might you be pregnant	☐	☐	

FAMILY HISTORY

HAVE ANY OCCURED IN YOUR FAMILY	YES	NO	DESCRIBE
Bleeding problems	☐	☐	
Anesthetic complications	☐	☐	
Genetic diseases	☐	☐	

SOCIAL HISTORY

HAVE YOU PARTICIPATED IN ANY OF THE FOLLOWING	YES	NO	DESCRIBE
Alcohol use	☐	☐	
Tobacco use	☐	☐	
Recreational drug use	☐	☐	
Are you disabled	☐	☐	

MEDICATIONS (Include all non-prescription medications, aspirin, vitamins, and herbals)

NAME OF MEDICATION	DOSE	HOW OFTEN TAKEN

Have you taken aspirin containing products in the last two weeks? ☐ **Yes** ☐ **No**

Have you taken steroid or cortisone-type drugs within the last two years? ☐ **Yes** ☐ **No**

ALLERGIES (Include medications, environmental agents, foods, latex, tape, etc.)

NAME	DESCRIBE ALLERGIC REACTION

PERSON COMPLETEING THIS HEALTH HISTORY

I certify that I have understood all items and have answered the questions accurately and completely.

Name _____ Date _____

Signature _____ Date _____

CANTERBURY ORAL &
MAXILLOFACIAL SURGERY

FINANCIAL POLICY

Thank you for choosing Canterbury Oral & Maxillofacial Surgery as your oral surgery provider. We are commited to your treatment being successful. The following is a statement of our Financial Policy.

We accept cash, checks, all major credit cards, or payment plans through Care Credit to meet your financial obligations at the time services are received.

INSURANCE

We will accept assignment of insurance benefits. If we are a participating provider for your insurance company, your estimated deductible and co-insurance amounts are due at the time of treatment. **Any balance due after your insurance company has paid their portion or denied payment is your responsibility.** Your insurance policy is a contract between you and your insurance company. We cannot bill your insurance company unless you give us current and correct information which includes:

- Copy of the current insurance identification card
- Social security number
- Full and legal name
- Birth date of the insured
- Current address

Please be aware that some, and perhaps all, of the services provided may be non-covered services.

If you do not have insurance, full payment is due the day of service. **We do not accept Medicaid or Medicare. We will not submit any claims to Medicaid or Medicare.**

USUAL AND CUSTOMARY RATES

Our practice is commited to providing the best treatment for our patients and we change what is usual and customary for our area. Please understand that some insurance companies arbitrarily determine usual and customary fees based on their own interest.

RESPONSIBLE PARTY

The responsible party is obligated for full payment at the time of service.

MISCELLANEOUS FEES

Past due accounts may be subject to collection fees and/or third party action.

If there are extunuating financial circumstances, please communicate this to our staff. We must collect fees so that we can meet our financial obligations and continue to serve the people of Western Kansas. Thank you for understanding.

RESCHEDULING FEE

It is the policy of Canterbury Oral & Maxillofacial Surgery that if a surgery appointment must be cancelled or rescheduled we ask that it be done 48 business day hours in advance. Business hours are Tuesday - Thursday 8:00 - 4:30 and Friday 8:00 - 4:00.

I understand that if I choose to reschedule or cancel my surgical appointment less than 48 business day hours in advance of the appointed time, **I MAY BE ASSESSED A $100 RESCHEDULING FEE** that is due prior to rescheduling my appointment. This assessed fee wil be applied to the cost of my surgery. If an overpayment should result on my account, a refund will be made to me.

I understand and agree to the Financial Policy

Signature of Patient or Responsible Party _____ Date _____

CANTERBURY ORAL & MAXILLOFACIAL SURGERY

NOTICE OF PRIVACY PRACTICES

I, _____ , hereby acknowledge that I have been furnished an opportunity to
Patient Name

read and review the Notice of Privacy Practices set forth by Canterbury Oral & Maxillofacial Surgery. A copy of this notice is available by request for my personal use. I have been given the opportunity to ask any questions I may have regarding this notice. I understand that I have agreed to the standards set forth by law within the Notice of Privacy Practices Act.

Patient, parent or guardian signature _____ Date _____

PERSONS INVOLVED IN CARE OR PAYMENT OF CARE

Canterbury Oral & Maxillofacial Surgery may disclose my protected health information (including schedule/rescheduled appointments, test results, diagnoses, treatment plan, billing questions, etc.) to the following people involved in my care or payment of care. **If you decline to give such permission, leave the following blank.**

IN RELATION TO PATIENT

Spouse _____

Children _____

Other _____

Parent(s) _____

MEANS OF COMMUNICATION

Canterbury Oral & Maxillofacial Surgery may communicate with me as follows about my appointments, test results, treatment options, breach notification, or any other matter related to my treatment or payment of my treatment. **If you decline to give such permission, check "NO." At least one box must be marked "YES."**

YES	NO	
☐	☐	Calling me at my home phone number
☐	☐	Leaving messages on my home voice mail
☐	☐	Calling me at my work phone number
☐	☐	Leaving messages on my work voice mail
☐	☐	Calling me at my cell phone number
☐	☐	Leaving messages on my cell phone voice mail
☐	☐	E-mailing me at _____
		(I understand that such communications will not be encrypted)
☐	☐	Calling the following individual(s) _____
		At the following number(s) _____
☐	☐	Leaving a message with any individual who answers my phone(s)

PLEASE NOTIFY THE STAFF IF YOU WISH TO MAKE ANY CHANGES TO THESE DIRECTIVES

Original to be maintained in patient's permanent medical record.

CANTERBURY ORAL &
MAXILLOFACIAL SURGERY

INSTRUCTIONS FOR IV ANESTHESIA

PREPARING FOR YOUR SURGERY

You will need to take some days off work or school to give yourself enough time to recover. **At a minimum, plan on taking the day of surgery and the day after surgery off.** Your recovery will progress better if you do not rush back to full activity.

EATING

If you are having IV anesthesia, do not eat or drink anything for 6 hours prior to your surgery. **To do otherwise may be life threatening.** However, it is important that you take any scheduled medications (high blood pressure, antibiotics, etc.) or any prescriptions that we may have provided for pre-medication. In these instances you are allowed only a small sip of water. If you are having only local anesthesia, normal eating and drinking is premitted.

TRANSPORTATION

Arrange to have a responsible adult (at least 18 years of age) come with you who can drive you home. We ask that this person remain in our waiting area (with the car available) during the procedure and not plan to "run errands" during that time (approximately one hour). Home care instructions will be given to this person as well, and they should assist you during your home recovery. You should not be left unattended for the first 5 hours after surgery and anethesia.

CLOTHING

Wear comfortable clothes. Choose a loose fitting top with short sleeves so the IV can be administered easily and a blood pressure cuff can be placed on your arm. Sensors for a heart monitor will be placed under your shirt. A pulse oximeter will be used on your finger, it is color senisitive, and so you must remove nail polish and/or acrylic nails. We ask that you do not wear contact lenses during the procedure.

PRESCRIPTIONS

The doctor may write prescriptions to be taken after surgery. Have your prescriptions filled within an hour of discharge from the surgery.

IF YOU HAVE ANY QUESTIONS OR CONCERNS PRIOR TO YOUR SURGERY, PLEASE CALL OUR OFFICE

Please upload insurance card image below

Please upload insurance card images below:

Card#1

Front side:

Back side:

Card#1

Front side:

Back side:

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