



## Canterbury Oral & Maxillofacial Surgery

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Dear Patient,

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

- **Please complete the forms in their entirety** and sign where necessary.
- We will take a photocopy (front and back) of your insurance card(s) when you come in for your appointment. We need both medical and dental insurance information. **We do not accept Medicaid.**
- Please bring your personal calendar with you for scheduling your next appointment.

There is a map enclosed to assist you in your visit to our office. If you have any questions, please do not hesitate to call us at the above number. Office hours are Tuesday through Thursday 8:00-5:00, Friday 8:00-4:30, closed on Mondays and from 12:00-1:00.

Sincerely,

Canterbury Oral & Maxillofacial Surgery

Enclosures

**WELCOME TO OUR OFFICE**

Today's Date \_\_\_\_\_

Your first visit is consultation only. Surgery will be scheduled for a later 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 out this form completely in ink. If you have any questions or need assistance, please ask us—we will be happy to help you. All information will be kept confidential. Please print.

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

MailingAddress \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Home Ph. # \_\_\_\_\_ Work/Cell Ph. \_\_\_\_\_

Please circle appropriately:      Minor    Single    Married    Divorced    Widowed    Separated

Sex:    Male    Female      Spouse's Name \_\_\_\_\_

Have you or any family members been a patient here before? Name \_\_\_\_\_ Year: \_\_\_\_\_

Answer only if you are a dependent:

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Parent's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent's Home Ph.# \_\_\_\_\_ Parent's Work Ph.# \_\_\_\_\_

Places of employment \_\_\_\_\_

**PERSON FINANCIALLY RESPONSIBLE FOR THIS PATIENT?**

Name \_\_\_\_\_ Signature of person financially responsible \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph.# \_\_\_\_\_ Work Ph. # \_\_\_\_\_ Employer \_\_\_\_\_

Relationship to this patient? \_\_\_\_\_ SS # \_\_\_\_\_ DOB \_\_\_\_\_

**INSURANCE INFORMATION**      Subscriber's Name \_\_\_\_\_

Subscriber's Social Security # \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_

Do you have Dental Insurance?     Yes     No      Name of Company \_\_\_\_\_

Do you have Medical Insurance?     Yes     No      Name of Company \_\_\_\_\_

Physician's Name \_\_\_\_\_ General Dentist's Name \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**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 diagnosis 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 doctors 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 TIME OF SERVICE. I grant permission to the doctors or staff of this office to release medical information to my dentist or other medical personnel as deemed necessary in treating my current condition.

Patient, parent or guardian signature \_\_\_\_\_



# Canterbury Oral & Maxillofacial Surgery

## Medical History

Patient Name: \_\_\_\_\_ Date of Birth : \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Current Medical Conditions

### 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 Bisphosphonate Meds:	___	___	_____
Examples: Etidronate (Didronel); Tiluderonate (Skelid); Alendronate, (Fosamax); Risedronate (Actonel); Ibandronate (Boniva), Pamidronate, (Aredia); Zoledronate (Zometa); or (Reclast)	___	___	_____

**Females:** Might you be pregnant? \_\_\_ \_\_\_ \_\_\_\_\_

## Family History

Have any occurred in your family?	Yes	No	Describe
Bleeding problems	___	___	_____
Anesthetic complications	___	___	_____
Genetic diseases	___	___	_____

## Social History

Have you had any of the following?	Yes	No	Describe
Alcohol use	___	___	_____
Tobacco use	___	___	_____
Recreational drug use	___	___	_____
Are you disabled?	___	___	_____

**Have you had:**

Joint replacements?

Heart Valve Surgery?

**Yes**

**No**

**Describe**

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

**Medications** (Include all non-prescription meds, aspirin, vitamins, and herbals)

Name of Medication

Dose

How Often Taken

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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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

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

**Person Completing This Health History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS PAGE TO BE COMPLETED BY MEDICAL TEAM ONLY**

**Vital Signs:** For Medical Team Use Only

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_    Pulse: \_\_\_\_\_    Respirations: \_\_\_\_\_    Temperature: \_\_\_\_\_  
Height: \_\_\_\_\_    Weight: \_\_\_\_\_    O<sub>2</sub> Saturation: \_\_\_\_\_

**Doctor Reviewing This Form**

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

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**MEDICAL UPDATE:** I have reviewed my health history dated \_\_\_\_\_ and confirm that it accurately states past and present conditions.

**EXCEPTIONS:**

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\_\_\_\_\_  
Signature of Person completing Health Update

\_\_\_\_\_  
Date

**Doctor Reviewing This Form**

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

Signature: \_\_\_\_\_    Date: \_\_\_\_\_

## *Canterbury Oral & Maxillofacial Surgery*

### ***FINANCIAL POLICY***

Thank you for choosing Canterbury Oral & Maxillofacial Surgery as your oral surgery provider. We are committed 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.

#### ***Regarding 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 a copy of the current insurance identification card, social security number, full and legal name, birth-date of the insured, and 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.

#### ***Usual and Customary Rates.***

Our practice is committed to providing the best treatment for our patients and we charge 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 extenuating 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.

**I understand and agree to the Financial Policy:**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date