# Palm Valley Oral and Maxillofacial Surgery

**PATIENT INFORMATION**: ☐ Male ☐ Female ☐Single ☐Married ☐Divorced ☐Widow ☐Minor

Name ______________________________________________ Soc.Sec #______________________________

Address _______________________________________ Apt#_______ City______________ State_____ Zip________

Home Phone # _______________________ Work Phone #_________________________ Cell# ______________________

Date of Birth ____________________ Age__________ Email Address_____________________________________

If full time student, Name of School _________________________________________________________________

Employer ___________________________ Address______________________________ Occupation ________________

Name of parent/guardian accompanying minor _____________________________ Soc.Sec#_______________________

Relationship to minor _______________ Home# _________________ Work#______________ Cell# _______________

Address ____________________________________ Apt# ________ City_______________ State ____ Zip ___________

Employer _________________________ Address____________________________________ Occupation _____________

Phone number________________________

Contact in case of Emergency ________________________ Phone# ____________________ Relationship ___________

Name of friend or relative NOT living with you ________________________________ Phone ______________________

**PRIMARY DENTAL INSURANCE**

Name of Policy Holder/Primary _______________________ Soc. Sec # ____________________ DOB ____________

Name of Insurance Company _______________________________ Name of Employer ___________________________

Insurance Phone # _______________________ Group # _________________ Relationship to Patient ________________

**SECONDARY DENTAL INSURANCE**

Name of Policy Holder/Primary _________________________ Soc. Sec # ____________________ DOB ____________

Name of Insurance Company _______________________________ Name of Employer ___________________________

Insurance Phone # _______________________ Group # _________________ Relationship to Patient ________________

**PRIMARY MEDICAL INSURANCE**

Name of Policy Holder/Primary _________________________ Soc. Sec # ____________________ DOB ____________

Name of Insurance Company _______________________________ Name of Employer ___________________________

Insurance Phone # _______________________ Group # _________________ Relationship to Patient ________________

**SECONDARY MEDICAL INSURANCE**

Name of Policy Holder/Primary _________________________ Soc. Sec # ____________________ DOB ____________

Name of Insurance Company _______________________________ Name of Employer ___________________________

Insurance Phone # _______________________ Group # _________________ Relationship to Patient ________________

**Who may we thank for referring you to our office?**_____________________________________________________

**Patient's General Dentist** ________________________________________ **Phone #** ____________________________

*For children under 18 years of age, the parent accompanying the child to this appointment is deemed the responsible party for payment of this account.*

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to **Palm Valley Oral & Maxillofacial Surgery** and authorize the release of any information required to process my claims. I understand that regardless if I have insurance or not, that I am financially responsible for all services rendered. I authorize the use of this signature on all insurance submissions.

_______________________________________________________ _______________________________

Signature of patient or responsible party (if minor) Date

**PALM VALLEY ORAL & MAXILLOFACIAL SURGERY**
**CONFIDENTIAL MEDICAL HISTORY FORM**

Name: ________________________________________ Date: ____________________

DOB _______/________/________ Sex: M / F Ht. ________ Wt __________

**Medications**

Do you have any allergies to any medications or foods? Yes No
Please specify: ______________________________________________

Are you allergic to Latex? Yes No

List ALL medications, non-prescriptions, homeopathics, or herbals you have been taking for the **last 6 months** (include diet supplements)

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Have you ever taken any of the following medications for any reason: *(please circle)*
Zometa (zoledronic acid), Aredia (pamidronate), Actonel (risedronate), Fosamax (alendronate), Ostac or Bonefos (clodronate), Didronel (edtidronate), Boniva (ibandronate)

**Medical History**

Are you in good health? Yes No
Have you had any previous serious illnesses or hospitalization? Yes No

_________________________________________________________________________
_________________________________________________________________________

Has there been any significant change in your health this past year? Yes No
My last physical exam was on ________ / _________ / _________

Are you currently under the care of a physician? Yes No
If so, for what condition? ______________________________________________

Name and address of your physician __________________________________________
_________________________________________________________________________
Phone: _______________________________

Have you ever received a general or local anesthetic? Yes No
Have you had a reaction to general or local anesthesia? Yes No
Specify: _____________________________________________________________

Reactions to general or local anesthesia? (include you and/or your family) Yes No
Specify ______________________________________________________________

**Answer Yes or No to the following health questions; please be specific when necessary so that we may give you the best care.**

**Heart Health**

Do you currently see a Cardiologist (heart doctor) for any reason? Yes No
Have you ever had a heart attack? Date: ___________________ Yes No
Do you have angina? (chest pain) Yes No
Do you have Rheumatic Heart disease? Yes No
Do you have a heart murmur? Yes No
Do you take antibiotics before going to the dentist? Yes No
Do you have high blood pressure? Yes No
Do you have low blood pressure? Yes No
Do you take medication for elevated cholesterol? Yes No
Do you have damaged heart valves, artificial heart valves? Yes No
Do you have an abnormal heart rhythm or arrhythmia? Yes No
Do you have chest pain with exercise or physical exertion? Yes No
Do you have a history of Congestive Heart Failure (fluid on the lungs?)? Yes No
Hospitalization for this? Date: _____________________ Yes No

Do you experience shortness of breath after mild exertion? Yes No
Do your ankles swell? Yes No
Have you had a cardiac catheterization? Date: ____________________ Yes No
Do you have heart stents or have you had angioplasty? Yes No
Date: ________________________
Have you had a recent EKG? Date: ____________________ Yes No
Have you had a stroke? Date: ______________________ Yes No

**Lung Health**

Do you smoke currently? How much? _______________ For how long __________ Yes No
Have you smoked in the past and recently quit? Date: _____________________ Yes No
Do you have Asthma? Yes No
Do you use an inhaler regularly? Yes No
Do you currently have a cold, cough, or respiratory infection? Yes No
Have you had Tuberculosis or Valley Fever? Date:_____________________ Yes No
Do you have COPD, emphysema or bronchitis? Yes No
Do you use oxygen at home for your COPD or emphysema? Yes No
Do you have any sinus trouble? Yes No

**General Health**

Have you had/do you have Cancer of any type? Yes No
Specify: ____________________________________________________________
Have you been tested for HIV? When:____________ Result:______________ Yes No
Have you been tested for any form of Hepatitis? When:___________ Result:_______ Yes No
Do you have any bleeding problems or blood disorders such as anemia? Yes No
Do you have a problem with your thyroid? Yes No
Do you have GERD (acid reflux) or stomach ulcers? Yes No
Have you ever had a seizure, seizure disorder or epilepsy? Yes No
Do you have diabetes? Yes No
Are you on insulin? Yes No
Do you have liver disease? Yes No
Do you have kidney disease? Yes No
Do you think you may be pregnant or are trying to become pregnant? Yes No
Are you currently nursing? Yes No

**Social History** (For anesthetic reasons, honesty is imperative)

Do you take street drugs or diet pills? What type? _________________________ Yes No
Do you smoke marijuana? If yes how much/often? __________________________ Yes No
Do you drink excessive amounts of alcohol? Yes No
If yes how much/often? _______________________________________________
Do you have any medical conditions that we should be aware of? Yes No
Specify:__________________________________________________________

**Dental History**

Are you experiencing any pain at this time? Yes No
Do you clench or grind your teeth? Yes No
Do you have painful, popping, or clicking jaw joints? Yes No
Are you wearing contact lenses? Yes No
Are you wearing a removable dental appliance? Yes No
Have you had any problems with local anesthetic (freezing)? Yes No
Have you had any serious problems associated with dental work? Yes No
Specify:_________________________________________________________________

Chief Dental Complaint: _____________________________________________________

**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 oral surgeon, or any member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.**

**Patient/Parent/Legal Guardian signature:** ________________________________________

**Date:** ____________________________

Palm Valley Oral & Maxillofacial Surgery

# Understanding Your Insurance and Financial Obligation At Palm Valley Oral & Maxillofacial Surgery

Most dental insurance plans limit you to an annual amount that they will pay, usually between $1000 and $2500. Any treatment above the maximum is your responsibility.

If your insurance has not paid their percentage within 30 days of the claim being filed, we require that you pay the balance. Any insurance reimbursement will then be forwarded to you.

Also, most plans have limitations, restrictions, and disallowed treatments. These vary from plan to plan and vary from extremely limited coverage to very generous coverage. While many plans suggest a pre-estimate for treatment over a certain amount, this is never a guarantee of payment. We will obtain a pre-estimate for you if you request it. We do require that you be responsible for knowing any restrictions and/or limitations within your insurance plan. With so many plans available, we simply cannot keep track of all the individual restrictions.

Please understand that your relationship with us involves dental care and subsequent payment for services rendered. While we are happy to file your insurance claims for you, your relationship with your insurance company is ultimately your responsibility. If there is any additional help we can provide, please ask. We will do whatever is in our power to make your insurance details easier for you.

By signing below, I acknowledge that I have read and understand the information contained on this form. I understand that any balance not covered by my insurance is my responsibility. In addition, I understand that if reimbursement by my insurance is not received within 30 days, I will be responsible for paying my balance and any insurance reimbursement will then be forwarded to me.

Print Patient Name ______________________ Date ______________

Signature of Patient/Legal Guardian ______________________

Palm Valley Oral & Maxillofacial Surgery

# Consent for Use and Disclosure Of Health Information (HIPPA)

**Section A: Patient (or representative) Giving Consent:**

Name: ______________________________________________

Address: ______________________________________________

Telephone: ____________________ Email: ____________________

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**Section B: To the Patient – Please Read the Following Statements Carefully**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at anytime by contacting:
Contact Person: Sandi Steele, Office Manager
Telephone: (623)935-5774 Fax: (623)935-6524
Address: 1646 N. Litchfield Rd, Suite 130 Goodyear, AZ 85395

**Right to Revoke:** You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you if you revoke this consent.

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I, ____________________, have had full opportunity to read and consider contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ____________

*If this consent is signed by a personal representative on behalf of the patient, complete the following:*
*Name:* ______________________________ *Relationship to Patient* ____________

You are entitled to a copy of this consent after you sign it