MID-MARYLAND ORAL AND MAXILLOFACIAL SURGERY, PA
PATIENT REGISTRATION FORM

PATIENT		
NAME (First, Middle, Last, Suffix)	Date of Birth	Sex □ Male □Female
Address		Home Telephone
City, State, Zip	Email Address	Cell Phone#
Employer/College	Length of Employment/Year	Work Telephone
Social Security Number	College Student Status	Marital Status

RESPONSIBLE PARTY (For all minors, this is the parent/guardian ***accompanying*** the patient) □**SELF** or		
NAME (First, Middle, Last, Suffix)	Date of Birth	Sex □ Male □Female
Address (Street)		Home Telephone
City, State, Zip	Email address	Cell Phone#
Employer	Length of Employment	Work Telephone
Social Security Number	Relationship to Patient	Marital Status

PRIMARY DENTAL INSURANCE		**PRIMARY MEDICAL INSURANCE**	
Insurance Carrier Name	Employer	Insurance Carrier Name	
Insurance ID#	Group#	Insurance ID#	Group #
Subscriber (Policy Holder)		Subscriber (Policy Holder)	
Name:	DOB:	Name:	DOB:
Address:		Address:	
Phone#:	SS#	Phone#:	SS#:
Relationship to Patient:		Relationship to Patient:	
SECONDARY DENTAL INSURANCE		**SECONDARY MEDICAL INSURANCE**	
Insurance Carrier Name		Insurance Carrier Name	
Insurance ID#	Group#	Insurance ID#	Group #
Subscriber (Policy Holder)		Subscriber (Policy Holder)	
Name:	DOB:	Name:	DOB:
Address:		Address:	
Phone#:	SS#:	Phone#:	SS#:
Relationship to Patient:		Relationship to Patient:	

General Dentist	Physician Name	Whom should we thank for referring you?
IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?		
Name	Daytime Telephone	Evening Telephone
Address (Street, City, State, Zip)	Relationship to Patient	

ALL PAYMENTS ARE DUE AT TIME OF SERVICE.

Assignment of Benefits/Financial Agreement.

- I understand that the HIPAA law grants Provider authorization to use and disclose my medical/dental records for treatment/care and payment operations.
- I hereby authorize payment of health/dental insurance benefits directly to Mid-Maryland OMS, not to exceed the balance due of the providers' customary charges for the services rendered.
- I understand I will be responsible for all fees and charges deemed as my responsibility according to Mid-Maryland OMS and my health plan.
- I understand if I do not provide a VALID insurance card **before** services are provided, I will pay in full for the services rendered, then get reimbursed from my insurance company when and if it becomes VALID.
- I further agree that I will pay any outstanding amounts in accordance with Mid-Maryland OMS's rates and terms. Should the account be referred to an Agency for collection, I will pay reasonable attorney's fees and collection expenses, and I understand all delinquent accounts bear interest at the legal rate.
- I also understand it is my responsibility to determine which laboratory participates with my insurance plan. Errors in this determination may result in denial of payment by the insurance company in which case the financial responsibility will be my own.
- I understand I am responsible for all charges regardless of insurance coverage.

I CERTIFY I HAVE READ THE FOREGOING AND I AM THE PATIENT OR DULY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT. I AGREE TO THE TERMS STATED ABOVE.

Patient or Parent/Guardian (if minor) Signature: _____ Date: _____

Or

By signing as a Patient's Representative, I verify that I have the legal responsibility to make medical decisions for this patient.

Signature of Patient's Representative: _____ Relationship to Patient: _____ Date:_____

All payments are due at time of service. Your account may be paid by cash, check or credit card (Visa, MasterCard or Discover).

We also have Care Credit applications available for those who need payment arrangements. Please ask receptionist if you need more information.

MID-MARYLAND ORAL AND MAXILLOFACIAL SURGERY, PA
HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____ Patient ID: _____

Please answer all questions by circling Yes or No

DENTAL

1. Are you having discomfort at this time? Yes No
2. Have you ever had a bad reaction to dental treatment? Yes No
   If yes, explain _____
3. Date of last dental visit _____

MEDICAL

1. Are you in generally good health? Yes No
2. Has there been any change in your health in the last year? Yes No
3. Date of last physical exam: _____
4. Are you currently under a physician's care? Yes No
   Physician Name:_____
   Address: _____
   Phone: _____
5. Have you had any serious illnesses, hospitalizations or surgeries in the last five years? Yes No
   If so, explain: _____
6. Do you have or have you ever had:
   a. Rheumatic fever or rheumatic heart disease? Yes No
   b. Congenital heart disease? Yes No
   c. Heart attack? Stroke? Yes No
   d. High blood pressure? Yes No
   e. Heart surgery or pacemaker? Yes No
   f. Irregular heartbeat? Yes No
   g. Chest pain upon exertion? Yes No
   h. Shortness of breath when you lie down, or do you require extra pillows when sleeping? Yes No
   i. Artificial or replacement valves? Yes No
   j. Seasonal or environmental allergies? Yes No
   k. Hives, eczema or skin rashes? Yes No
   l. Sinus trouble, hay fever? Yes No
   m. Asthma, emphysema, COPD? Yes No
   n. Tuberculosis, Pneumonia, Bronchitis, Pleurisy? Yes No
   o. Epilepsy, seizures, fainting spells, convulsions? Yes No
   p. Psychiatric treatment? Yes No
   q. Liver disease, hepatitis, jaundice? Yes No
   r. Digestive problems, ulcers, colitis, diverticulitis? Yes No
   s. Kidney disease, dialysis? Yes No
   t. Diabetes, hypoglycemia? Yes No
   u. Excessive thirst or dry mouth? Yes No
   v. Arthritis or inflammatory rheumatism? Yes No
   w. Artificial or replacement joints? Yes No
   x. Have you had any vital organs transplanted? Yes No
   y. Autoimmune or immunosuppressive disorder? Yes No
   z. Chronic fatigue, night sweats, chronic cough or recurrent mouth sores? Yes No
7. Have you had abnormal bleeding with previous extractions, surgery or trauma? Yes No
8. Have you had a transfusion? When? _____ Yes No
9. Do you bruise easily? Yes No
10. Do you have a blood disorder such as anemia? Yes No
11. Have you had surgery or radiation treatment for a tumor, growth or other condition? Yes No
12. Do you snore or have trouble sleeping at night? Yes No
13. Do you have sleep apnea and/or use CPAP? Yes No
14. Are you taking any of the following medications?
    a. Antibiotics? Yes No
    b. Blood thinners (Aspirin, Plavix, Coumadin)? Yes No
    c. Blood pressure medication? Yes No
    d. Bisphosphonates (Fosamax, Actonel, Boniva)? Yes No
    e. Steroids (Prednisone, Cortisone, etc.)? Yes No
    f. Insulin or oral medications to treat diabetes? Yes No
    g. Tranquilizers? Yes No
    h. Antihistamines? Yes No
    i. Nitroglycerin? Yes No
    j. Chemotherapy? Yes No
    k. Herbal, holistic, or natural remedies? Yes No
15. Please list all medications you are currently taking:
16. Are you allergic or have you reacted adversely to:
    a. Local anesthesia? Yes No
    b. Penicillin or amoxicillin? Yes No
    c. Sulfa or any other antibiotics? Yes No
    d. Codeine or other narcotics? Yes No
    e. Barbiturates, sedatives, or sleeping pills? Yes No
    f. Aspirin or ibuprofen? Yes No
    g. Iodine? Yes No
    h. Latex? Yes No
17. Please list any allergy not mentioned above:
18. Do wear contact lenses? Yes No
19. Do you play contact sports? Yes No
20. Do you smoke or chew tobacco? Yes No
    How much/often _____
21. Do you drink alcohol? Yes No
    How much/often _____
22. Do you use marijuana or Illicit Drugs? Yes No
23. Do you have any other disease, disorder or condition not listed on this page that you feel the doctor should know about? Yes No

FOR WOMEN ONLY:

Are you pregnant? Yes No
Are you nursing? Yes No
Do you take birth control pills or hormone therapy? Yes No

Completed by (Signature):

_____ Date_____

Remarks: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I _____, have received a copy of the Mid-Maryland's
Patient's Name **Notice of Privacy Practices.**

X_____ **_____**
Signature of Patient/Parent/Guardian **Date**

PLEASE CHECK BELOW TO AUTHORIZE MID-MARYLAND ORAL AND MAXILLOFACIAL SURGERY TO LEAVE MESSAGES REGARDING APPOINTMENTS, TEST RESULTS, BILLING, ETC. AT THE VARIOUS LOCATIONS.

Preferred phone number for voice mail
_____ Home
_____ Cell

Specifically list name and relationship of any persons with whom we may discuss your care and account:
_____

_____ Send text appointment reminders **_____**

_____ Talk with a family member

_____ Send email: _____@_____

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Information for Insured Patients: Patients with insurance are asked to pay the deductible and estimated patient portion at the time of treatment. We are more than happy to file your insurance claim for you. Please keep in mind that the estimated portion is just that, an estimate. Ultimately it is the responsibility of the insured to know the level of benefit and be prepared to pay for services if they are deemed "not a covered service" or if a maximum applies. Filing insurance claims is a courtesy that we extend to our patients. We make every effort to follow up on unpaid insurance claims; however if we have not received payment after 60 days, we ask you to discuss your claim with your insurance company.

Cancellation Policy: Please understand that your surgery appointment is NOT a routine office appointment and we MUST enforce the following cancellation policy:

A 10% fee ($100 minimum) of the estimated charges will be assessed if:

1. You do not follow the preoperative instructions given to you by phone or in writing, thus requiring your surgery to be rescheduled.
2. You do not provide 2 business days notice if you are unable to keep your appointment.
3. You do not show up for your appointment.
4. You are over 10 minutes late for your appointment, requiring your surgery to be rescheduled.

Cancellations MUST be made during normal business hours. We do not accept cancellations via our answering machine.

X_____ _____
Patient/Parent/Guardian Date