PATIENT REGISTRATION

DATE:_____ HOME PHONE_____

PATIENT NAME_____ I PREFER TO BE CALLED_____

STREET ADDRESS_____ SOC. SEC. NO._____

CITY_____ STATE_____ ZIP CODE_____

CELL PHONE_____ WORK_____ E-MAIL_____

SEX [] M [] F AGE_____ BIRTH DATE_____ DRIVER'S LICENSE# _____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

CITY_____ STATE_____ ZIP CODE_____

REFERRED BY_____ PHONE_____

May we contact You, a Spouse, Family or friends regarding your health information, including leaving messages at your home number, sending written mail and the same at your place of employment? Yes No

ACCOUNT HOLDER (If patient is a minor only)

NAME_____ RELATIONSHIP_____

ADDRESS (If different than patients)_____

PHONE_____ CELL PHONE_____

SOC. SEC. NO._____ BIRTH DATE_____ DRIVER'S LICENSE_____

DENTAL INSURANCE

NAME OF INSURED_____ SEX [] M [] F

SOC. SEC. NO._____ BIRTH DATE_____ PHONE_____

EMPLOYER_____

BUSINESS ADDRESS_____

DENTAL INSURANCE CO._____ PHONE_____

GROUP NO._____ I.D. NO._____

SECONDARY/MEDICAL INSURANCE

PATIENT COVERED BY ADDITIONAL INSURANCE? []YES []NO [] MEDICAL [] DENTAL

NAME OF SECONDARY DENTAL INSURANCE:_____

NAME OF INSURED_____ SOC. SEC. NO._____ BIRTH DATE_____

GROUP NO._____ I.D. NO._____

INSURANCE ADDRESS_____ PHONE_____

NAME OF MEDICAL INSURANCE:_____

NAME OF INSURED_____ SOC. SEC. NO._____ BIRTH DATE_____

GROUP NO._____ I.D. NO._____ PHONE_____

MEDICAL ADDRESS_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____

_____ Name of Ins. Company (ies)

and assign directly to San Tan Oral Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature of Responsible Party Relationship Date

HEALTH HISTORY

PATIENT NAME_____ BIRTHDATE___/___/___ PATIENT #_____

This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Today's date_____
Occupation_____
Previous occupations_____
Marital status_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Street drugs (type & amount per day)_____
Usual weight_____My ideal weight_____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)

_____
_____
_____

Are you now or have you ever been treated for substance abuse?_____ If yes, What for ?_____
Treatment facility or Doctor name and contact info:

_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:

_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs):

_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

_____
_____
_____

When was your last physical exam?_____
Name of doctor_____Phone_____
Any history of family violence?_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	system problems	no	yes	Stroke	no	yes
Mumps	no	yes	Cancer	no	yes	Hepatitis	no	yes
Chickenpox	no	yes	Polio	no	yes	Ulcer	no	yes
Scarlet Fever	no	yes	Glaucoma	no	yes	Kidney disease	no	yes
Diptheria	no	yes	Sinus problems	no	yes	Thyroid		
Smallpox	no	yes	Blood or Plasma			Disease	no	yes
Pneumonia	no	yes	Transfusions	no	yes	Bleeding		
Rheumatic Fever	no	yes	Back trouble	no	yes	Tendency	no	yes
Heart Disease	no	yes	High/low Blood			Any other		
Arthritis	no	yes	Pressure	no	yes	Disease	no	yes
Venereal Disease	no	yes	Artificial joints	no	yes			
Anemia	no	yes	MS/MD/Cerebral Palsy			(Please list)		
Hemophilia	no	yes		no	yes	_____		
Pacemaker	no	yes	Asthma	no	yes	Date of last Chest x-ray:		
Epilepsy	no	yes	Psychiatric care	no	yes	_____		
Migraine	no	yes	AIDS or HIV+	no	yes	Are you pregnant?	no	
Headaches			Infectious Mono	no	yes	yes		
Tuberculosis	no	yes	Bronchitis	no	yes	**Allergies to anesthetics**	no	yes
Diabetes	no	yes	Mitral Valve					
nervous			Prolapse	no	yes			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature_____Date_____

_____

_____

Physicians Signature_____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION **DATE _____**

I authorize **San Tan Oral Surgery** to use and disclose the health and medical information of _____ for the purposes of Treatment, Payment and Health Care Operations.* (Name of patient)

***Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

***Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review **SAN TAN ORAL SURGERY's** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. **Please verify that you have received a copy of our Notice by placing your initials here: _____.**

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

May we contact **You**, a **Spouse**, **Family** or **friends** regarding your health information. Including leaving messages at your **home number**, sending **written mail** and the same at your **place of employment?**
Yes No [PLEASE CIRCLE ALL THAT APPLY]

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that San Tan Oral Surgery has already used or disclosed the information in reliance on this Consent.

_____
Signature of Patient

_____
Signature of Person Authorized by Law [Guardian]

_____
Date

INSURANCE NOTICE

What is dental insurance and how does it work

Dental insurance is a contract between your employer and a dental Insurance company. The benefits you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company and not your dental office. The goal of most dental insurances is to provide basic care for specific dental services. The services selected are based on the cost of the policy to your employer and the negotiated arrangements with the insurance company.

The quote you are given IS ONLY AN ESTIMATE! Your insurance company does not guarantee phone quotes and or computer quotes. Based on our experience with the insurance company we will calculate your co-pay as closely as possible, therefore resulting in either a refund of overpayment or a balance WHICH IS DUE UPON RECEIVING A STATEMENT FROM OUR OFFICE.

YOUR CO-PAY IS DUE AT TIME OF SERVICE.

We do not submit pretreatment estimates for same day extractions.

If your insurance has not responded to our claim within 45 days we will look to you for payment.

Please sign and date below so that we know you understand our policy.

Thank you

_____ _____

Signature ***Date***

PHARMACY INFORMATION

PATIENT NAME: _____

DOB: _____

PATIENT PHONE NUMBER: _____

PHARMACY OF CHOICE: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

I consent to the information provided above is correct and give San Tan Oral Surgery permission to submit all given prescriptions electronically to the pharmacy I have listed.

PATIENT SIGNATURE: _____

DATE: _____