**PATIENT INFORMATION:**

Name: Nickname: Date:

Date of Birth: Age: Height: Weight: Gender:

Social Security #: Marital Status:

Mailing Address: City: State: Zip Code: Home Phone: Cell Phone: E-mail: Employer: Work Phone: Occupation:

Who is your: Dentist: Orthodontist: Physician:

Who were you referred by? Preferred Pharmacy:

Reason for referral:

**Guarantor/Insured Name**: Dental Insurance Company:

Date of Birth: Social Security or Ins. ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Spouse, Parent, Emergency Contact: Phone:

**HEALTH HISTORY:**

Are you in good health? Yes No

Are you receiving any medical care currently? Yes No

If yes, specify

History of Surgery

Are you taking any medications currently or occasionally to include prescription, over the counter, supplements, CBD products?

If yes, list

Are you allergic to any medications or food, if so what type of reaction?

If yes, list

Check all that apply:

Any heart ailment

High blood pressure

Take blood thinners

Any bleeding tendency

Any blood disease

Lung disease, COPD, asthma

Smoking, past or present

\_\_\_\_\_ E-cig/Vaping, past or present

\_\_\_\_\_ Recreational Drugs, past or present

\_\_\_\_\_ Alcohol consumption, past or present

Hepatitis or liver disease

Kidney disease

Glaucoma or other eye disorders

Cancer

Head or neck radiation treatments

Diabetes, A1C\_\_\_\_\_\_ avg glucose \_\_\_\_\_

Tuberculosis

Sinus problems

\_\_\_\_\_ Pregnant or nursing

Rheumatic fever

Seizures

Artificial joint replacement, when?\_\_\_\_\_

Broken jaw or facial trauma

Thyroid Hypo- or Hyper-

HIV or AIDS

Other:

**FINANCIAL AGREEMENT:**

I understand, **payment in full is expected at time of service**. **Dr. Lussier is not a contracted provider for any insurance plans.**

**INSURANCE PLANS:**

Kerrville OMS will file a claim on your behalf as a courtesy. **Dr. Lussier is not a contracted provider for any insurance plans.** The reimbursement for the services provided would be based on our standard fee schedule. Any difference between the rate paid by your insurance company and standard fees is your responsibility. Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. You have a relationship with your insurance company, Kerrville OMS is a part of that relationship. My signature below is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits form unless otherwise stated payable to me.

**INFORMED CONSENT:**

I have been informed and understand the potential risks related to oral surgery procedures which include but are not limited to swelling, discomfort, bleeding, infection, chipped teeth, bone fracture, jaw joint discomfort, inability to open the mouth fully and discoloration of the skin. Some oral surgery procedures including the administration of local anesthesia can cause numbness to the lips, tongue, teeth, gums or chin. In most all cases, this numbness is temporary. However, in rare cases it can be permanent. A more detailed consent form may accompany this paperwork depending on the nature of my surgical needs.

**ACKNOWLEDGEMENT- RECEIPT OF PRIVACY PRACTICE NOTICE:**

The privacy and protection of your patient information is of the utmost importance to Kerrville OMS. As required by the Federal Health Insurance Portability and Accountability Act (HIPAA) Regulations, a Notice of Privacy Practices must be provided by all healthcare providers to their patients. At Kerrville OMS a copy will be provided upon request. It is available on our website and accompanies the new patient paperwork. Kerrville OMS reserves the right to modify the privacy practices outlined in the notice.

# I hereby authorize my medical and dental providers to release my protected health information relevant to my medical/dental history which may influence or benefit my planned surgery at Kerrville OMS. This authorization allows communication to and from Kerrville OMS via phone, fax, email, or written correspondence. I also authorize the following friends or family members to be informed of my care should they inquire on my behalf:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

# To the best of my knowledge, all the information I have provided is true and correct. I have read and understand the financial policy and have received or have been offered a copy of the Patient Privacy Practices by signing below, agree to abide by their guidelines.

Signature of Patient or Legal Representative Date

Printed Name of Patient or Legal Representative Relationship