**PATIENT INFORMATION:**

Name: Nickname: Date:

Date of Birth: Social Security #: Marital Status:

Age: Height: Weight: Gender:

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**: Date of Birth:

**Guarantor /Insured** Social Security or Ins. ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 that payment in full is expected at time of service**.

**INSURANCE PLANS:**

**Dr. Lussier is not a contracted provider for any insurance plans. Payment in full is due at each visit.**

As a courtesy**,** Kerrville OMS will file a dental claim on the patient’s behalf. The reimbursement for the services

provided would be based on your insurance carrier’s guidelines. Please remember that insurance is considered a method of assisting in the cost of care and there is no guarantee of payment. You have a relationship with your insurance company; Kerrville OMS is not a part of that relationship. Your signature below is your authorization for the release of information required by your insurance carrier to process any claim(s) submitted on you or your dependent’s behalf. If Dr. Lussier agrees to accept payment of benefits directly from your insurance carrier, your signature below does hereby authorize payment directly to the provider named on the insurance benefits form unless otherwise stated payable to you, the insured.

**COMPLIANCE WITH ALL PRE-OPERATIVE AND POST-OPERATIVE INSTRUCTIONS WILL BE IMPORTANT FOR A SUCCESSFUL EXPERIENCE AND SUCCESSFUL SURGERY. NON-COMPLIANCE MAY RESULT IN A POOR SURGICAL OUTCOME, ADDITIONAL FEES AND/OR SURGERY, AND DISMISSAL FROM THE PRACTICE.**

**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:

# 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 my signature, I agree to abide by the policies and guidelines of Kerrville OMS.

Signature of Patient or Legal Representative Date

Printed Name of Patient or Legal Representative Relationship