Kerrville
Oral & Maxillofacial Surgery
Implants, Extractions, Facial Reconstruction

## PATIENT INFORMATION:

Name: _____ Nickname: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Social Security #: _____ Marital Status: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

Dental Insurance Company: _____ Insured Name: _____

Date of Birth: _____ Social Security #: _____

Name of Spouse, Parent, Emergency Contact: _____ Phone: _____

Who is your? Dentist: _____ Orthodontist: _____ Physician: _____

Who were you referred by? _____ Preferred Pharmacy: _____

Reason for referral: _____

## HEALTH HISTORY:

Yes No Are you in good health?

Yes No Are you receiving any medical treatment now?

If yes, specify _____

Yes No History of Surgery _____

Yes No Are you taking any medications now?

If yes, list _____

Yes No Are you allergic to any medications or food?

If yes, list _____

Check any that apply:

_____ Any heart ailment
_____ High blood pressure
_____ Take blood thinners
_____ Any bleeding tendency
_____ Any blood disease
_____ Lung disease or asthma
_____ Smoking history or use
_____ Hepatitis or liver disease
_____ Kidney disease
_____ Glaucoma
_____ Other eye disorders

_____ Sinus problems
_____ Diabetes
_____ Tuberculosis
_____ Head or neck radiation treatments
_____ Rheumatic fever
_____ Seizures
_____ Artificial joint replacement
_____ Broken jaw
_____ Pregnant or nursing
_____ HIV or AIDS
_____

## INFORMED CONSENT:

I have been informed of and understand the potential risks related to this surgical procedure 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 the vast majority of 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.

Patient's Initials _____

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## FINANCIAL AGREEMENT:

I understand, if not covered by insurance, payment is expected at time of service.

## INSURANCE PLANS:

Dr. Lussier is not a contracted provider for any insurance plans. We will file a claim on your behalf. The reimbursement for the service provided would be based on our standard fee schedule. Any difference between the rate paid by your insurance company and standard fees will be your responsibility. Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. 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.

## 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 is available on our website, attached to the new patient paperwork, and a copy will be provided upon request. Kerrville OMS reserves the right to modify the privacy practices outlined in the notice.

I hereby authorize Dentist(s) and Physician(s), listed on the previous page, to release my protected health information relevant to my medical 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 (print name and relationship if desired):_____

_____

To the best of my knowledge, all of 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

Patient's Initials _____