Patient Registration Form

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. # _____ E-mail _____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(____)_____ Cell (____)_____ ❑ I permit the office to communicate with me via text message on my cell phone.

Race: WHITE/CAUCASIAN: _____ AFRICAN AMERICAN : _____ HISPANIC: _____ NATIVE AMERICAN:_____OTHER: _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Referred By _____

Dentist_____ _____ Orthodontist _____ _____

First Name Last Name First Name Last Name

Medical Dr. _____ _____ Preferred Pharmacy_____ Tel. (____)_____

First Name Last Name

Nearest relative or friend(for emergency reasons) other than spouse:_____ Tel. (____)_____

Employer _____ Bus. Tel. (____)_____

Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ _____ S.S.#_____ Birth Date_____ Age_____

First Name Last Name

Tel. (_____)_____ Cell (_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Employer_____ Bus. Tel. (____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ _____ Relation _____ S.S.#_____ Birth Date_____

First Name Last Name

Street_____ Apt._____ City_____ State_____ Zip_____

Employer_____ Bus. Tel. (____)_____

INSURANCE INFORMATION:

Student:. . . . . ❑ Full Time ❑ Part Time ❑ Not. . . . . School Name and Address _____ _____

Marital Status:. . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated School Name Address

Employed:. . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ ___ _____

Address City St Zip

Bus. Tel. (____)_____ Plan _____

Ins. Co. Name_____ I.D. #_____

Address _____ _____ ___ _____

Address City St Zip

Tel. (____)_____Group Name_____

Group # _____

Insured Party _____ _____

First Name Last Name

Relation _____

Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (____)_____

Address _____ _____ ___ _____

Address City St Zip

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ ___ _____

Address City St Zip

Bus. Tel. (____)_____ Plan _____

Ins. Co. Name_____ I.D. #_____

Address _____ _____ ___ _____

Address City St Zip

Tel. (____)_____Group Name_____

Group # _____

Insured Party _____ _____

First Name Last Name

Relation _____

Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (____)_____

Address _____ _____ ___ _____

Address City St Zip

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ ___ _____

Address City St Zip

Bus. Tel. (____)_____ Plan _____

Ins. Co. Name_____ I.D. #_____

Address _____ _____ ___ _____

Address City St Zip

Tel. (____)_____Group Name_____

Group # _____

Insured Party _____ _____

First Name Last Name

Relation _____

Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (____)_____

Address _____ _____ ___ _____

Address City St Zip

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ ___ _____

Address City St Zip

Bus. Tel. (____)_____ Plan _____

Ins. Co. Name_____ I.D. #_____

Address _____ _____ ___ _____

Address City St Zip

Tel. (____)_____Group Name_____

Group # _____

Insured Party _____ _____

First Name Last Name

Relation _____

Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (____)_____

Address _____ _____ ___ _____

Address City St Zip

PATIENT DISCLOSURE INTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❑Home Telephone ❑Written Communication ❑ O.K. to leave message with detailed information

❑ O.K. to mail to my home address ❑ Leave message with call-back number only ❑ O.K. to mail my work/office address

❑ O.K. to fax to number indicated (____) _____

❑ Work Telephone (____) _____ ❑ Other (Fax/Cell, etc.) (____)_____

❑ O.K. to leave message with detailed information _____

❑ Leave message with call-back number only_____

I allow you to give my clinical information to or answer questions from:

_____ RELATIONSHIP: _____

_____ RELATIONSHIP: _____

_____

Print Name of Patient

_____ _____

Patient Signature or LEGAL GUARDIAN Date

Patient Medical History Form

HEALTH HISTORY: Patient Name_____

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit? _____

	YES	NO
1. ***Height***_____ ***Weight***_____ Are you in good health?	❑	❑
2. Have there been any changes in your general health in the past year?	❑	❑
3. Are you under the care of a physician? ***Date of last visit***_____	❑	❑
If so, for what are you being treated?_____		
4. Are you presently or have you ever been under the care of a psychiatrist or admitted to a psychiatric mental health facility?	❑	❑
5. Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
If so, describe _____		
6. Do you have unhealed / recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth?	❑	❑
If so, describe where _____		
7. Do you have a prosthetic joint / implant? If so, describe where_____	❑	❑
8. Have you had a heart valve replacement or vascular graft?	❑	❑
9. Have you ever had general anesthesia?	❑	❑
10. Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
11. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑
12. Are you adopted or raised by someone other than your biological parents?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	Note
13. Rheumatic fever?			
14. Damaged heart valves / mitral valve prolapse?			
15. Heart murmur?			
16. High blood pressure?			
17. Low blood pressure?			
18. Chest pain / angina?			
19. Heart attack(s)?			
20. Irregular heart beat?			
21. Cardiac pacemaker?			
22. Heart surgery?			
23. Pneumonia, bronchitis, chronic cough?			
24. Hay fever / sinus problems?			
25. Snoring?			
26. Sleep apnea / CPAP?			
27. Difficult breathing / other lung trouble?			
28. Tuberculosis?			
29. Emphysema?			
30. Do you smoke or vape? If so, how much a day			
31. Do you use chewing tobacco?			
32. Blood transfusion?			
33. Blood disorder such as anemia? 35. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	Note
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach ulcer / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Autoimmune disease?			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of marijuana or other drug use?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			
67. Have you ever been the victim of mental or physical abuse?			
68. Have you ever been diagnosed with PTSD? (post-traumatic stress disorder)?			

Patient Name_____

WOMEN ONLY: (QUESTIONS 71–74)	Yes	No
69. Is there a possibility of pregnancy?.....	❑	❑
70. Are you nursing?.....	❑	❑

	Yes	No
71. Expected delivery date?.....	❑	❑
72. Are you taking birth control pills?.....	❑	❑

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.

ARE YOU NOW TAKING:	YES	NO	Note
73. Any kind of medication, drug, pills?			
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
75. Have you ever taken diet pills?			
76. Any natural product, herbal supplement or homeopathic remedy?			
77. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia/Denosumab, Fosamax/Alendronate, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

78. Are you taking, or have you ever taken cancer treatment drugs
❑ Bevacizumab/Avastin ❑Sunitinib/Sutent ❑ Other

79. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other_____

Treating doctor:_____

80. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list below

81. Please list any medications you are currently taking:

Medication	Dosage	Frequency

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home?_____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe_____

Do you wish to speak to the Dr. privately about anything?
❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	Note
82. Local anesthetic (numbing meds.)?			
83. Penicillin?			
84. Other antibiotics?			
85. Sulfa drugs?			
86. Sodium pentothal / Valium /other tranquilizers			
87. Aspirin?			
88. Amoxicillin			
89. Codeine or other narcotics?			
90. Latex			
91. Soy?			
92. Eggs / yolk?			
93. Sulfites?			
94. Do you have any known allergies?			

95. Please list any allergies **<u>other than</u>** drug allergies:

96. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name	

Is there a family history of: ❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury_____

Insurance company handling the claim_____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____)_____

Patient Name_____

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ **X** _____ **X**_____ **X**_____
Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees, and court costs.

X_____ **X**_____
Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ **X**_____
Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

❑ I permit the office to communicate with me via text message on my cell phone.

X_____ **X**_____ **X**_____
Signature of patient *(Parent or Guardian if Minor)* **Doctor** **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**

Patient Privacy Acknowledgement Notice Signature

Southeastern Oklahoma Oral and Maxillofacial Surgery

Hans Igou, DDS

I acknowledge that I have been given the opportunity to read a copy of SEOOMS's Notice of Privacy Practices. This notice describes how Dr. Igou may use and disclose my protected health information, certain restriction on the use and disclosure of my healthcare information, and rights I may have regarding that information.

I hereby authorize Dr. Igou to furnish information concerning any treatment rendered to me to my insurance carrier; to any physician who referred me to SEOOMS; to any medical practitioner or dentist that Dr. Igou may refer me to for further therapy or treatment; and to anyone I designate in the space below. Please list in the spaces below, the names of people who SEOOMS can speak with regarding your personal information.

WE CAN SHARE INFORMATION <u>ONLY</u> WITH THE PEOPLE LISTED.

_____ _____

_____ _____

_____ _____

You may leave appointment reminders/medical information on my message machine. Yes (circle one) No

You may contact me at work. The number is: _____ Yes (circle one) No

The authorization remains in effect unless revoked by me in writing.

Patient or responsible party signature _____ Date _____

Witness signature _____ Date _____

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Due to state and federal HIPAA Privacy & Confidentiality Regulations, NO CELL PHONE USE is allowed in ANY Patient care areas. This includes using your device for PHONE CALLS, PHOTOS, VIDEOTAPING or RECORDING.

X_____

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For Office use only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained.

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining ACKNOWLEDGEMENT.

_____ An emergency situation prevented us from obtaining ACKNOWLEDGEMENT.

_____ Other: Explain below.

_____