PATIENT INFORMATION

Patient's Name _____ Age _____
Address _____ Apt. No. _____
City _____ State _____ Zip Code _____
Home Phone: _____ Cell (_____) _____ Sex: M_____ F_____
Date of Birth _____ Patient's Soc. Sec. No. _____
Drivers License Number _____ Full Time Student: Y_____ N_____
School: _____
Employer _____ Work Phone _____

INCASE OF EMERGENCY CONTACT

Name _____ Phone No. _____

REFERRAL INFORMATION

General Dentist Name or Group _____
Orthodontist _____
Primary Care Physician _____ Phone No. _____
Cardiologist _____ Phone No. _____

BILLING INFORMATION

Name _____ Phone No. _____
What is their relationship to you? _____
Birth Date: _____ SS# _____
Address _____
City _____ State _____ Zip Code _____
Employer _____ Phone No. _____

We request that any & all financial arrangements be made days in advance and prior to surgery. Payment is due at the time services are rendered, unless other arrangements have been made in advance with our office.
There will a $50 fee for no show & cancellation of an appointment with less than 24 hours notice.

INSURANCE INFORMATION

DENTAL CARRIER:
Name of Insurance _____ Group No. _____
Name of Policy Holder _____ ID _____
Do you have a secondary policy? _____

MEDICAL CARRIER:
Name of Insurance _____ Group No. _____
Name of Policy Holder _____ ID _____
Do you have a secondary policy? _____

By signing this form you hereby authorize the release of any medical & dental information necessary to complete the processing of any & all insurance claims. You also certify that the above information you provided is true and correct.
In addition, you authorize the payment of any insurance benefits to Dr. Steven Darmstadt.

Signature _____ **Today's Date** _____
Patient / Parent / Legal Guardian Signature ONLY

Steven D. Darmstadt D.D.S., Inc.
Practice Limited to Oral & Maxillofacial Surgery
1751 W. Romneya Drive, Suite C
Anaheim, CA 92801
www.Oral-Surgery.net

Acknowledgement of Financial Policy

In this new world of self-paid healthcare, it is important that our patients, whether insured or uninsured, understand our office's financial policy. Our policy is designed to ensure staff members and patients alike comprehend and agree how charges for services rendered are to be paid, what payments are required from whom, when payments are expected, and how payments should be made. Also, outlining the key points of our policy and informing patients of what they are expected to pay, allows patients the opportunity to raise questions about our billing, if insured, before they receive care, rather than after the fact, when it is too late to adjust our services to their circumstances.

Fee and Payment Options

All payments are due at the time services are rendered. We do not under any circumstances waive fees for co-payments, deductibles, non-covered procedures or offer any other form of discounted care. Insured patients are expected to pay their coinsurance in full at the time services are rendered. Uninsured patients are expected to pay for the entire cost of care in full at the time services are rendered. We gladly accept the following forms of payment; cash, personal checks with valid identification, money orders, credit cards (including Visa, MasterCard, American Express and Discover), and ATM/debit cards. As a courtesy, we also offer financing through Care Credit. Returned checks are subject to a $25 service fee and are immediately reported to the State of California's Bad Check Program, TeleCheck and the credit bureaus.

Dental and/or Medical Claim Submissions

The purpose of this section is to provide you with information on the following: procedures for claim submissions, plan provisions, if any, and your role as the participating insured/member. Providing accurate and reliable information is essential when seeking reimbursement from insurance companies. ***Your insurance is a contract between you and the insurance company and We are not party to that contract.*** The relationship between providers and insurance companies is that of an independent contractor. Therefore, insurance companies **DO NOT** provide any guarantee of payments to providers for; consultations, initial exams, x-rays, proposed treatment, emergency treatment, local or general anesthesia, or routine surgical care. **The total cost of care provided is ultimately the responsibility of the patient or responsible party.**

*By signing here, you are stating that you understand and agree to the above information.*_____
Signature of patient/responsible party

We are not contracted with any medical insurance companies, P.P.O., H.M.O., I.P.A., or medical groups. We are however currently participating with most dental insurance companies and selective dental plans. Services and care that have been or will be, provided by Steven D. Darmstadt D.D.S., Inc., and the related decisions of said care and services, are the sole responsibility of the patient/responsible party. This includes, but is not limited to, full financial responsibility of the TOTAL cost of care.

We will gladly submit a claim to your primary insurance carrier for our services that have been rendered, provided the patient is eligible at the time. Dental claims will be submitted for completed services only by either standard US mail or electronic submission. Dental claims are submitted on a standard "ADA approved" dental claim form. Medical claims will be submitted for completed services by standard US mail only on a HCFA 1500 claim form. A filing fee of $20 may be charged for filling more than one insurance claim form, if it is in addition to the primary insurance.

TURN OVER

Patients/Responsible parties are responsible for any outstanding balances to their account, even if the insurance company has been billed for services on behalf of the patient for a portion of, or all of, the total cost of care. **Outstanding balances must be paid in full within 90 days of the date of service no exceptions will be made.** The outstanding balance can either be divided into three (3) payments or less within the 90-day period or it can be paid in full within the 90-day period. Payments are accepted in person during our normal business hours, by telephone, and or by mail.

By signing here, you are stating that you understand and agree to the above information. _____

Signature of patient/responsible party

Upon receipt of your insurance company's payment, you will be reimbursed for any over-payments you may have made, if any. Refunds are mailed to the responsible party fifteen to thirty (15-30) days after the receipt of the insurance company's payment, unless we have been instructed otherwise.

Delinquent Accounts

Please be advised that if an account has not been paid promptly in accordance with our financial policy, and has reached it's 90-day (ninety) due date and the responsible party has neglected to pay the outstanding balance, one last attempt will be made by our office to keep the account in good standing. A FINAL NOTICE will be sent by mail to the responsible party, as a courtesy. This will be the last opportunity to settle the matter before we begin legal proceedings to recover the amount due. If the outstanding balance has not been paid 15-days from the date of the FINAL NOTICE or if we have not been contacted by the responsible party of the account within such time to discuss satisfactory arrangements, we will begin legal proceedings to recover the amount due. This may include Small Claims Court and an adverse report to the credit bureaus.

By signing here, you are stating that you understand and agree to the above information. _____

Signature of patient/responsible party

Incidental Fees and Charges

Any fees or charges for incidentals will be applied to the account in addition to any outstanding balances.

- Unpaid accounts that have been forwarded to Small Claims Court for judgments against them are subject to: court cost, processing fees, attorney fees and collection fees.
- Returned checks will incur a $25 bank charge in addition to: collection cost, processing fees, and TeleCheck fees.
- Chart copies are subject to the following: $25 per x-ray, $0.10 per page, $24 per hour for labor, and shipping.

GUARANTY

For value of services received, the undersigned responsible parties hereby guarantee absolutely and unconditionally prompt payment of the foregoing promissory financial policy and agree to pay all cost of collection and/or enforcement of the policy and the enforcement of this guaranty.

This Guaranty shall continue in full force and be binding upon the undersigned responsible parties until the account has been fully paid and discharged.

_____

Primary Responsible Party/Guarantor's Signature

_____

Primary Responsible Party/Guarantor's Name Please PRINT

_____ _____

Patients Name Today's Date

Patients Name: _____

Patients Birth Date: _____

Answer all questions. Answers to the following questions are for our records and are considered confidential.

Have you had any food or drink/s today ..... YES NO
Are you in "GOOD" general health ..... YES NO
Has there been any changes in your health within this past year... YES NO
Are you under the care of a physician now ..... YES NO
If YES, what is the condition being treated _____
_____
When was your last physical: _____
What is the name of your physician; _____
Do you or have you had any serious illness or operations..... YES NO
Describe: _____
_____
Have you been hospitalized for any reason within the past 5 years.... YES NO
Describe: _____
_____
Do you drink alcoholic beverages ..... YES NO

Do you have or have you had any of the following MEDICAL CONDITIONS

1. Rheumatic fever or Rheumatic heart disease ..... YES NO
2. Chronic Bronchitis or Emphysema ..... YES NO
3. Any of the following Cardiovascular Diseases ..... YES NO
   a. Heart Attack ..... YES NO
   b. Heart Surgery ..... YES NO
   c. Coronary Artery Disease ..... YES NO
   d. Irregular Heart Beat ..... YES NO
   e. High Blood Pressure ..... YES NO
   f. Angina ..... YES NO
   g. Heart Murmur ..... YES NO
      a. Do you require a premedication? Y N
   h. Mitral Valve Prolapse ..... YES NO
      a. Do you require a premedication? Y N
   i. Pacemaker ..... YES NO
4. Stroke ..... YES NO
5. Asthma ..... YES NO
   a. Is it: Sports Induced, Allergy Induced or Seasonal
   b. Do you use an inhaler ..... YES NO
   c. How often: _____
   d. When was your last onset/attack? _____
6. Neck and or Back problems ..... YES NO
7. Seizures ..... YES NO
8. Diabetes ..... YES NO
   a. Type I or Type II
9. Hepatitis, Jaundice or Liver Disease ..... YES NO
10. Osteoarthritis ..... YES NO
11. Rheumatoid Arthritis ..... YES NO
12. Osteoporosis ..... YES NO
13. Stomach Ulcers ..... YES NO
14. Kidney Problems ..... YES NO
15. Tuberculosis ..... YES NO
16. Persistent cough or cough up blood ..... YES NO
17. Low Blood Pressure ..... YES NO
18. Venereal Disease ..... YES NO
19. AIDS, ARC, or Positive for HIV ..... YES NO
20. Prosthetic Joint Replacement ..... YES NO
    a. Do you require premedication? Y N
21. Other Disease or Condition not listed? _____

_____
_____
Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma ..... YES NO
Do you bruise easily ..... YES NO
Have you ever required a blood transfusion ..... YES NO
Explain the circumstances _____
Do you have a blood disorder ..... YES NO
Describe; _____
Have you had head and/or neck Radiation Therapy for a tumor, growth, or cancer ..... YES NO
If yes; When: _____ Where: _____

Please list any drugs or medications you take; _____
_____
_____
_____

Are you taking any of the following?

1. Antibiotics ..... YES NO
2. Anticoagulants (blood thinners) ..... YES NO
3. Medicine for High Blood Pressure ..... YES NO
4. Cortisone (steroids) ..... YES NO
5. Tranquilizers ..... YES NO
6. Aspirin ..... YES NO
7. Insulin, Glyburide, Metformin, or Similar Drug ..... YES NO
8. Medication for your HEART ..... YES NO
9. Nitroglycerin ..... YES NO
10. Have you ever taken Phen-Phen ..... YES NO
11. Birth Control Pills ..... YES NO
12. Have you ever taken any of the following: Fosamax, Actonel, Boniva, Zometa, or Aredia ..... YES NO
    a. If so, for how long: _____
13. Others: _____
_____

Are you allergic or have you reacted adversely to any of the following?

1. Local Anesthetics ..... YES NO
2. Antibiotics ..... YES NO
   a. Penicillin/Amoxicillin ..... YES NO
   b. Sulfa ..... YES NO
   c. Other: _____
3. Barbiturates, Sleeping Pills, or Sedatives ..... YES NO
4. Aspirin ..... YES NO
5. Iodine ..... YES NO
6. Latex ..... YES NO
7. Eggs or Soy products ..... YES NO
8. Other: _____
_____

Do you have popping or clicking in your jaw joints ..... YES NO
Do you get frequent headaches ..... YES NO
Have you ever had any serious trouble associated with previous Dental treatment ..... YES NO
If so, please explain: _____
_____
_____
Do you have any disease or medical condition NOT LISTED that you Think I should be aware of ..... YES NO
If so, explain; _____
_____
Are you pregnant (women) ..... YES NO
Do you smoke ..... YES NO
If so, how much; _____

I have completed this health questionnaire completely and to the best of my ability. I have advised you and your staff of any and all my medical conditions of which I am aware.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Signature of Dr. Darmstadt Date

_____ _____
Signature of Surgical Team Staff Member Date

HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

1. Authorization

I authorize **DR. STEVEN D DARMSTADT** (healthcare provider) to use and disclose the protected health information described below.

- Billing, Insurance Claims, Referrals, Pathology, Progress Notes, Letters & Narratives
- X-rays and radiology reports
- Correspondences' with referring dentist or doctors

2. Effective Period: Before and during any treatment or consultations.

3. Extent of Authorization (OPTIONAL)

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. □ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until the **COMPLETITION OF MY TREATMENT** (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative **Date**

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date