Welcome to Our Practice

Mr. Mrs. Ms. Dr. First Name _____ M _____ Last Name _____
Nickname _____ Have you ever been a patient of our practice? Yes No
Street Address _____ Mailing Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (_____) _____ Ext. _____
Birthdate _____ / ____ / ____ Age _____ Sex M F Cell Phone (____) _____
Social Security # _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Drivers License # _____ State _____
I was referred to this office by _____ General Dentist _____
Medical Doctor _____ Medical Doctor's Phone(_____) _____
IN CASE OF EMERGENCY CONTACT _____ Phone (_____) _____
Employer _____ or School _____

INSURANCE INFORMATION

1 – Patient: Student: Full Time Part Time School Name / Address _____

Please circle one. Do you belong to a PPO, HMO, POS, Medicare, Medicaid or Workers Comp?

2 – Who will be responsible for your account? ☐ **Self** ☐ **Spouse** ☐ **Father** ☐ **Mother** ☐ **Other** _____
(if self, skip to number 4)
Name _____ Soc. Sec. # _____ Home Phone (_____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ D.O.B. _____ Cell (_____) _____ Tel (_____) _____

3 – Spouse or other guarantor information (if different from above)
Name _____ Relationship _____ Soc. Sec. # _____ Home Phone (_____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ D.O.B. _____ Cell (_____) _____ Tel (_____) _____

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PRIMARY MEDICAL INSURANCE COMPANY
(if none, write none)
Employer _____
Insur. Co. Name _____
Address _____
_____ Tel (_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
ID # _____
Sex: ☐ M ☐ F Date of Birth _____
Street _____
City, State, Zip _____
Tel (_____) _____ S.S. # _____

PRIMARY DENTAL INSURANCE COMPANY
(if none, write none)
Employer _____
Insur. Co. Name _____
Address _____
_____ Tel (_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
ID # _____
Sex: ☐ M ☐ F Date of Birth _____
Street _____
City, State, Zip _____
Tel (_____) _____ S.S. # _____

SECONDARY MEDICAL INSURANCE COMPANY
(if none, write none)
Employer _____
Insur. Co. Name _____
Address _____
_____ Tel (_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
ID # _____
Sex: ☐ M ☐ F Date of Birth _____
Street _____
City, State, Zip _____
Tel (_____) _____ S.S. # _____

SECONDARY DENTAL INSURANCE COMPANY
(if none, write none)
Employer _____
Insur. Co. Name _____
Address _____
_____ Tel (_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
ID # _____
Sex: ☐ M ☐ F Date of Birth _____
Street _____
City, State, Zip _____
Tel (_____) _____ S.S. # _____

Health History

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 medication that you may be taking could have an important interrelationship with the care you that 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: _____

1 – Are you in good health? _____ Height _____ Weight _____ Lbs.

2 – Have there been any changes in your general health in the past year? _____
If so, please explain: _____

3 – Are you under the care of a physician? _____ Date of last visit _____ / _____ / _____
If so, please explain: _____

4 – Have you had any serious illness, operation, or been hospitalized in the past five years? _____
If so, please explain: _____

5 – Have you had joint replacement surgery (i.e. knee or hip replacement)? Yes No

6 – Have you had heart valve surgery or a vascular graft? Yes No

7 – Have you or any member of your family had problems / reactions to General Anesthesia (i.e. malignant hyperthermia)? Yes No
If so, please explain: _____

8 – Have you had any adverse effect from dental treatment in the past? _____
If so, please explain: _____

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	Yes	No	NOTES
9 -	Rheumatic Fever?			
10 -	Damaged heart valves / mitral valve prolapse?			
11 -	Congenital heart disease?			
12 -	Heart murmur?			
13 -	High blood pressure?			
14 -	Low blood pressure?			
15 -	Chest pain, angina?			
16 -	Heart attack(s)?			
17 -	Irregular heart beat?			
18 -	Cardiac pacemaker?			
19 -	Heart surgery?			
20 -	Bronchitis, chronic cough?			
21 -	Asthma?			
22 -	Hay fever / sinus problems?			
23 -	Tuberculosis?			
24 -	Emphysema?			
25 -	Difficult breathing / other lung problems?			
26 -	Do you smoke? How much?			
27 -	Blood transfusion?			
28 -	Blood disorder such as anemia?			
29 -	Bruise easily?			
30 -	Bleeding tendency?			
31 -	Jaundice, hepatitis, or liver disease?			
32 -	Infectious mononucleosis?			
33 -	Gall bladder trouble?			
34 -	Fainting spells?			
35 -	Convulsions, epilepsy?			
36 -	Stroke?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	Yes	No	NOTES
37 -	Thyroid Trouble?			
38 -	Diabetes			
39 -	Low blood sugar?			
40 -	Kidney trouble?			
41 -	Are you on dialysis?			
42 -	Swollen ankles, arthritis or joint disease?			
43 -	Stomach ulcers or colitis?			
44 -	GERD (reflux disease)?			
45 -	Contagious diseases?			
46 -	Sexually transmitted diseases?			
47 -	Any disease, drugs, or transplant operation that may suppress your immune system?			
48 -	Recurring infections of any kind?			
49 -	Delay in healing?			
50 -	A tumor, growth or cancer?			
51 -	Radiation treatment or chemotherapy?			
52 -	Chronic fatigue / night sweats?			
53 -	Osteoporosis?			
54 -	A history of drug abuse?			
55 -	A history of alcohol abuse?			
56 -	Contact lenses?			
57 -	Eye disease / glaucoma?			
58 -	Psychiatric treatment, nervous disorder or breakdown?			
59 -	A removable dental appliance?			
60 -	Malignant hyperthermia			
61 -	Jaw popping, clicking, pain in jaw joint, "TMJ"?			

MEDICATION

	ARE YOU NOW TAKING...	Yes	No	NOTES
62 -	Thyroid medication?			
63 -	Antibiotics or sulfa drugs?			
64 -	High blood pressure medicine?			
65 -	Steroids (Cortisone, etc.)?			
66 -	Tranquilizers (Valium, etc.)?			
67 -	Insulin, other drugs for diabetes?			
68 -	Digitalis, Nitroglycerin, Inderal, other heart medication?			
69 -	Blood thinners (i.e. Coumadin, Aspirin)?			
70 -	Street drugs?			
71 -	Any kind of natural product, herbal supplement, or homeopathic remedy?			

	ARE YOU NOW TAKING...	Yes	No	NOTES
72 -	Have you ever taken diet pills? (Fen-Phen, Redux, etc.)?			
73 -	Have you ever sought professional care for drug abuse, alcoholism or emotional disorders?			
74 -	Please list any other medications you are taking:			

ALLERGIES

	ARE YOU ALLERGIC TO OR HAD A REACTION TO ...	Yes	No	NOTES
75 -	Local anesthetics (Novocaine, etc.)?			
76 -	Penicillin, Amoxicillin or other antibiotics?			
77 -	Barbiturates, sedatives?			
78 -	Sodium pentothal, valium or other tranquilizers?			
79 -	Aspirin / Ibuprofen?			
80 -	Codeine or other pain killers?			

	ARE YOU ALLERGIC TO OR HAD A REACTION TO ...	Yes	No	NOTES
81 -	Other medications?			
82 -	Please list any allergies other than drug allergies (i.e. food allergies)			
83 -	Iodine?			
84 -	Latex or rubber products?			

WOMEN

85 -	Is there a possibility of pregnancy?			
86 -	Estimated delivery date __ / __ / __			
87 -	When was your last menstrual period? __ / __ / __			

88 -	Are you nursing?		
89 -	Are you taking birth control pills?		

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? **Yes** **No**

Do you wish to speak to the doctor privately about anything? **Yes** **No**

IS THIS VISIT RELATED TO AN ACCIDENT? Auto Yes No Work Related Yes No

Date of injury: _____ Insurance Co. handling this claim: _____ Claim # _____

Name of Attorney / Adjustor _____ Tel (_____) _____

Can we leave a message on your home and / or work answering machine / voicemail regarding treatment or appointment confirmation Yes No

Whom may we speak with regarding your treatment, appointment time and / or changes if you are unavailable? Please mark any that apply.

any family member at home co-workers specific person only (list below)

Name _____ Relationship _____

Home Tel _____ Work Tel _____ Cell _____

I certify that I have read and I understand the questions above. I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided is complete and accurate. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any member of his staff, responsible for any errors of omission that I may have made in the completion of this form.

Patient's (or legal guardian's) signature: _____ Date _____

Relationship if not patient's signature: _____

Fees & Payments

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. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE. I UNDERSTAND THAT MY INSURANCE COMPANY CANNOT GUARANTEE PAYMENT UNTIL THEY HAVE RECEIVED THE CLAIM AND DETERMINED THAT IT IS A COVERED BENEFIT AND / OR MEDICALLY NECESSARY. You will be responsible for all collection costs, attorney fees, and court costs or any unpaid balance after 60 days.

I understand that if I do not wish to provide my Social Security number, I will be required to pay in advance for services with cash, money order, or credit card.

Authorization to pay benefits to Mark Moore, D.M.D., P.C.

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

I understand and agree that any credit granted to me shall be paid promptly in accordance with terms and agreements; that the creditor may add one and one half percent (1.5%) per month to any unpaid balance and in the event of default I will pay reasonable collection charges and / or attorney fees, or other applicable charges.

There will be a $40.00 charge for returned checks.

Patient's (or legal guardian's) signature: _____ Date _____

Relationship if not patient's signature: _____

Authorization

I authorize my surgeon and his 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.

Patient's (or legal guardian's) signature: _____ Date _____

Relationship if not patient's signature: _____

Authorization for Release of Medical / Dental Records

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes photocopies of medical and / or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

Patient's (or legal guardian's) signature: _____ Date _____

Relationship if not patient's signature: _____

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have been provided the opportunity to review the privacy notice for Mark Moore, D.M.D., P.C.

Patient's (or legal guardian's) signature: _____ Date _____

Relationship if not patient's signature: _____

In order to verify your identity without unnecessary disclosure of Protected Health Information (PHI), please provide an answer to one of the following questions:

Favorite Color _____ Pet's Name _____ City of Birth _____

MARK MOORE, D.M.D.,P.C.
ORAL & MAXILLOFACIAL SURGERY

2048 Windward Lane
Gainesville, GA 30501
Tel: 770.297.7888
Fax: 770.297.7833

FINANCIAL POLICY

We feel that everyone benefits when there is a definite and clear financial agreement prior to treatment. An estimate of your total fee here will be given at consultation. To make your financial arrangements as easy for you as possible, we have the following methods of payment:

☐ PLAN 1 "Payment Upon Service"
"Entire fee is due the day of treatment."
We accept cash, personal check, Mastercard, Visa, Discover, and American Express

☐ PLAN 2 "Insurance"
Your deductible and your co-payment will be required of you at time of service. This includes patients on specific insurance plans with a set co-pay and insurance of which we are members.

☐ PLAN 3 "Care Credit"
In order to keep health care costs down, we offer payment plans through Care Credit finance company. If you are interested, please see the receptionist for an application. This needs to be completed prior to treatment so payment arrangements can be made.

PLEASE NOTE:

FEES & PAYMENTS:

Please remember that insurance is considered a method of reimbursing the patients 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 by your insurance company. **Your agreement with the insurance company is between you and your insurance company.** If you fail to pay for your treatment and collection procedures are required, you are responsible for costs of collection which will represent 40% of the outstanding balance.

If the insurance company does not remit payment within 60 days after the forms have been submitted, we will bill you the remaining balance due and payable upon receipt from you. If there is any overpayment (taking your surgical deposit into consideration), you will be reimbursed once payment is received from the insurance company. We are happy to help you file the necessary forms to insure that you receive the full benefits of your policy, but make no guarantee of payments of any estimated coverage. Our practice can assure you that our fees are reasonable. There will be a 1.5% Service Charge fee monthly applied to accounts over 60 days.

If you are on a specific insurance plan that requires you only see certain doctors, it is your responsibility to make sure Dr. Moore is participating in your plan.

If you do not wish to provide your Social Security number, full payment will be required in advance via money order, cash, credit card, or cashier's check only.

CANCELLATION POLICY: We require a 24-hour cancellation notice. A $100.00 fee will be applied to your account if insufficient notice is given.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to be made directly to Mark Moore, DMD, P.C. Please be advised that there will be a $40.00 charge for returned checks.

I hereby certify that I have fully read and agree with all terms and conditions.

Signature:_____ Date:_____

Responsible Party

Thank you for your cooperation,

Mark Moore, DMD, P.C.