WELCOME TO

WESTFIELD ORAL SURGERY ASSOCIATES

PATIENT REGISTRATION INFORMATION **TODAY'S DATE:**____________________

PATIENT NAME____ DATE OF BIRTH:__________________

HOME ADDRESS:____

SOCIAL SECURITY:______________________________ HOME PHONE:______________________________

CELL PHONE:__________________________________ WORK PHONE:______________________________

DENTIST NAME AND ADDRESS:____

ARE YOU A STUDENT:___________ SCHOOL NAME AND LOCATION_____________________________________

EMPLOYER NAME:____

EMPLOYER ADDRESS:____

EMERGENCY CONTACT NAME:__________________________________ RELATIONSHIP:__________________

EMERGENCY CONTACT PHONE NUMBER:____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY NAME:____

DENTAL INSURANCE COMPANY ADDRESS:____

RELATIONSHIP TO INSURED: ____

INSURED'S NAME_____________________________________ DATE OF BIRTH:_______________________

SOCIAL SECURITY:___________________________ PHONE NUMBER: __________________________

EMPLOYER ADDRESS:___________________________ PHONE NUMBER:__________________________

POLICY ID NUMBER:___________________________ GROUP NUMBER:__________________________

MEDICAL INSURANCE COMPANY NAME:____

MEDICAL INSURANCE COMPANY ADDRESS:____

RELATIONSHIP TO INSURED: ____

INSURED'S NAME_____________________________________ DATE OF BIRTH:_______________________

SOCIAL SECURITY:___________________________ PHONE NUMBER: __________________________

EMPLOYER ADDRESS:___________________________ PHONE NUMBER:__________________________

POLICY ID NUMBER:___________________________ GROUP NUMBER:__________________________

WESTFIELD ORAL SURGERY ASSOCIATES

DENTAL AND MEDICAL HISTORY

DATE OF LAST DENTAL EXAM:_______________ DATE OF LAST DENTAL X-RAYS:_________________________

DENTIST NAME AND ADDRESS:____

DO YOU HAVE ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)

__BAD BREATH
__BURNING SENSATION ON TONGUE
__CLICKING OR POPPING OF JAW
__FOOD COLLECTION BETWEEN TEETH
__GUMS SWALLEN OR TENDER
__LOOSE TEETH OR FILLINGS
__ORTHODONDIC TREATMENT
__SENSITIVITY TO SWEETS
__BLEEDING GUMS
__CHEW ON ONE SIDE OF MOUTH
__DRY MOUTH
__FOREIGN OBJECT
__JAW PAIN AND TIREDNESS
__MOUTH BREATHING
__PAIN AROUND EAR
__SENSITIVITY TO BITING
__BLISTERS ON LIPS/MOUTH
__CIGARETTE, PIPE OR CIGAR SMOKING
__FINGERNAIL BITING
__GRINDING TEETH
__LIP OR CHEEK BITING
__MOUTH PAIN, BRUSHING
__SENSITIVITY TO COLD OR HEAT
__SORES OF GROWTHS IN MOUTH

HOW OFTEN DO YOU BRUSH:____________________________HOW OFTEN DO YOU FLOSS:_________________________________

DO YOU CURRENTLY HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY)

__AIDS
__ARTIFICAIL HEART VALVE
__BACK PROBLEMS
__CANCER
__CIRCULATORY PROBLEMS
__COUGH, PERSISTENT OR BLOODY
__CONTACT LENSES
__GLAUCOMA
__HEART PROBLEMS
__HIGH BLOOD PRESSURE
__JAUNDICE
__LIVER DISEASE
__NERVOUS PROBLEMS
__RADIATION TREATMENTS
__SCARLET FEVER
__SKIN RASH
__SWELLING OF FEET OR ANKLES
__TONSILS
__ULCER
__ANEMIA
__ARTIFICIAL JOINTS
__ABNORMAL BLEEDING
__CHEMICAL DEPENDENCY
__CONGENITAL TREATMENTS
__DIABETES
__EPILEPSY
__HEADACHES
__HEPATITIS
__HIGH CHOLESTEROL
__JAW PAIN
__LOW BLOOD PRESSURE
__PSYCHIATRIC CARE
__RESPIRATORY DISEASE
__SHORTNESS OF BREATH
__SPECIAL DIET
__SWALLEN NECK GLANDS
__TUBERCULOSIS
__VENERAL DISEASE
__ARTHRITIS, RHEUMATIC
__ASTHMA
__BLOOD DISEASE
__CHEMOTHERAPY
__CORTISONE TREATMENTS
__EMPHYSEMA
__FAINTING OR DIZZINESS
__HEART MURMUR
__HERPES
__HIV POSITIVE
__KIDNEY DESEASE
__MITRAL VALVE PROLAPSE
__PACEMAKER
__RHEUMATIC FEVER
__SINUS TROUBLE
__STROKE
__THYROID PROBLEMS
__TUMOR OR GROWTH IN HEAD/NECK
__WEIGHT LOSS, UNEXPLAINED

ANY PREVIOUS SURGERIES:____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:____

____

____

LIST ANY ALLERGIES:____

____

PHARMACY NAME AND PHONE NUMBER:____

WESTFIELD ORAL SURGERY ASSOCIATES

FINANCIAL AGREEMENT AND RESPONSIBILITY

A. I___________________________________, the undersigned, have insurance with ___________________________________ (insurance company) and assign directly to Dr. Philip Geron or Westfield Oral Surgery Associates, all benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. Deductibles or co-payments, if applicable, must be made at the time of service. If patient overpayment is made based on pre-determination or pre-authorization estimates, patient reimbursement will be made once insurance payments are made.

SIGNATURE:____DATE:____________

B. **<u>FINANCIAL AGREEMENT</u>** Please be advised, that Westfield Oral Surgery does not represent any insurance carrier, nor is Westfield Oral surgery responsible for any determinations made by your insurance. Insurance policies are agreements between the patient and the insurance carrier. It is the patient's responsibility to understand their policies and guidelines as to covered and non-covered procedures. I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance plans. Estimated fees for services will be provided upon request after examination. If payment cannot be made in full at the time of service, any fees still not paid within 30 days of service will be subject to a 1.5% monthly interest and all legal/collection costs will be the patient's/guardian's responsibility. Once all patient balances are cleared and a patient credit is determined, a refund, if any, can be processed.

SIGNATURE:____DATE:______________

C. **<u>MINOR/CHILD CONSENT</u>** I, ______________________(parent/guardian) being the parent of ______________________(child's name) do hereby request and authorize the staff to perform the necessary services for my child, including examinations, x-rays, administration of appropriate anesthetics which are deemed advisable by the doctor.

SIGNATURE:____DATE:_______________

D. Westfield Oral Surgery strives to protect your privacy. We are required by law to:

- Maintain the privacy of protected health information
- Give you access to this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect
- **<u>A copy of the HIPAA Privacy Policy is available at the front desk for your review.</u>**

SIGNATURE:____DATE:________________