HEALTH HISTORY

TO OUR PATIENTS:

Although oral and maxillofacial surgeons treat the area in and around your mouth, your mouth is part of your entire body. Any health problems you have or medications you take could affect the care you are receiving. Thank you for answering the following questions. Your answers are confidential and are for our record's only.

Name _____

Date _____

Date of Birth _____ Sex M / F

Height _____ Weight _____

	YES	NO
Are you in good health?	☐	☐
Have there been any changes in your general health in the past year?	☐	☐
Are you under the care of a physician?	☐	☐

Date of last visit: _____

If so, for what are you being treated? _____

	YES	NO
Have you been hospitalized or had any operations in the past five years? If "yes", please state what was done:	☐	☐
Are you taking drugs or medications? *Please list them:*	☐	☐

When did you last have anything to eat or drink?

Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel for osteoporosis, chemotherapy for multiple myeloma, etc.)? ☐ ☐

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .	Yes	No	NOTES
1	Rheumatic Fever?				27	Convulsions, epilepsy?			
2	Damaged heart valves/mitral valve prolapse?				28	Stroke?			
3	Any pre-medication before dental care?				29	Thyroid trouble?			
4	Heart murmur?				30	Diabetes?			
5	High blood pressure?				31	Low blood sugar?			
6	Low blood pressure?				32	Kidney trouble?			
7	Chest pain, angina?				33	Are you on dialysis?			
8	Heart attack(s)?				34	Swollen ankles, arthritis or joint disease?			
9	Irregular heart beat?				35	Any artificial joints?			
10	Cardiac pacemaker?				36	Stomach ulcers?			
11	Heart surgery?				37	A tumor, growth, or cancer?			
12	Artificial heart valves or artery grafts?				38	Mental health problems?			
13	Bronchitis, chronic cough?				39	Removable dentures or retainers?			
14	Asthma?				40	Are you on a diet?			
15	Hayfever/sinus problems?				41	Eye disease/glaucoma?			
16	Tuberculosis?				42	X-Ray treatment/chemotherapy?			
17	Emphysema?				43	Blood Transfusion?			
18	Difficulty breathing?				44	Jaw joint or TMJ pain, clicking, or trouble opening your mouth?			
19	Any other lung trouble?				45	Sexually transmitted diseases?			
20	Do you smoke? How many a day?				46	Any disease, use any drugs, or had a transfusion, transplant or other operation which depressed your immune system?			
21	Blood disorder such as anemia?				47	Ever exposed to AIDS virus?			
22	Bruise easily?				48	Drug Addiction?			
23	Bleeding tendency (abnormal bleeding?)				49	Alcohol addiction?			
24	Jaundice, hepatitis or liver disease?								
25	Infectious mononucleosis?								
26	Fainting spells?								

ALLERGIES

ARE YOU ALLERGIC OR HAD A REACTION TO:	YES	NO
Local anesthetics?	☐	☐
Penicillin?	☐	☐
Other antibiotics? *(Please list)*	☐	☐
Sulfa drugs?	☐	☐
Barbiturates, sedatives or sleeping pills?	☐	☐
Aspirin?	☐	☐
Iodine?	☐	☐
Codeine?	☐	☐
Other narcotics? *(Please list)*	☐	☐
Other medications? *(Please list)*	☐	☐
Allergies other than drug allergies? *(Please list)*	☐	☐

_____

_____

_____

WOMEN:	YES	NO
Is there a possibility that you may be pregnant?	☐	☐
Estimated delivery date:	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?	YES	NO
	☐	☐

Please indicate:

_____

_____

_____

I certify that I have read and understand the 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 surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature of patient: _____

We welcome you as a patient!

(PLEASE PRINT) DATE _____

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ AGE _____
(FIRST MI LAST)

ADDRESS _____ CITY _____ STATE ____ ZIP _____

EMAIL _____

CHECK APPROPRIATE BOXES: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ MALE ❑ FEMALE

SOCIAL SECURITY # _____ HOME PHONE _____

PATIENT'S EMPLOYER _____ CELL PHONE _____

SPOUSE OR PARENT'S NAME _____ WORK PHONE _____

PHYSICIAN _____ DENTIST _____ ORTHODONTIST _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____ PHONE _____

PREFERRED PHARMACY _____

FINANCIALLY RESPONSIBLE PERSON FOR THIS ACCOUNT

❑ SELF (If patient is 18 or older) ❑ SPOUSE ❑ FATHER ❑ MOTHER ❑ Other _____

NAME _____ Social Security # _____ Birth Date _____ Age _____

Home Phone _____ Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Driver's Lic. # _____ Employer _____ Bus. Tel. _____

SIGNATURE OF FINANCIALLY RESPONSIBLE PERSON _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Tel. _____

Ins. Co. Name _____ Subscriber I.D. # _____

Address _____
(Address City State Zip)

Tel. _____ Group Name _____

Group # _____ Insured Party _____
(First Name Middle Last Name)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. _____

Address _____
(if different than patient) (Address City State Zip)

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Tel. _____

Ins. Co. Name _____ Subscriber I.D. # _____

Address _____
(Address City State Zip)

Tel. _____ Group Name _____

Group # _____ Insured Party _____
(First Name Middle Last Name)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. _____

Address _____
(if different than patient) (Address City State Zip)

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Tel. _____

Ins. Co. Name _____ Subscriber I.D. # _____

Address _____
(Address City State Zip)

Tel. _____ Group Name _____

Group # _____ Insured Party _____
(First Name Middle Last Name)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. _____

Address _____
(if different than patient) (Address City State Zip)

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Tel. _____

Ins. Co. Name _____ Subscriber I.D. # _____

Address _____
(Address City State Zip)

Tel. _____ Group Name _____

Group # _____ Insured Party _____
(First Name Middle Last Name)

Relation _____ Birth Date _____ Sex ❑ M ❑ F

S.S. # _____ Tel. _____

Address _____
(if different than patient) (Address City State Zip)

SIGNATURE

SIGNATURE OF PATIENT, OR PARENT IF PATIENT IS A MINOR _____

MARK J. LONERGAN, DMD ▲ KEITH A. NALLEY, DDS, MS ▲ PAUL J. HUIZINGA, DDS, MD ▲ KYLE M. KLOOSTER, DDS, MD
GEORGE D. KIRBY, DDS, MD ▲ ASHLEY N. HOULE, DDS, MD ▲ JEFFREY DEYOUNG, DDS ▲ MARK N. GRINZINGER, DDS, MD

FINANCIAL INFORMATION

Payment, in full, for all procedures will be due at time of service. For your convenience, we accept personal checks, cashiers checks, money orders, cash, Visa, MasterCard, American Express, Discover, Bank Debit, HSA, FSA and benefit cards as well as Care Credit (application available at www.carecredit.com or 800-365-8295). All credit card transactions are charged a 2% service fee. There is a $25.00 fee for any returned check.

1. Your estimated payment is required at time of service, which is based on your insurance provider/plan as of this date.
2. Payment of any balance due after sixty (60) days from the date of service is the responsibility of the patient and/or guarantor. This should give ample time for your insurance company to respond to your claim. We suggest you contact your insurance company if they have not paid within sixty (60) days from the date of service as the contract is between you, your employer, and the insurance company.

FEES: Any procedure not covered by/under your current insurance provider/plan, is the responsibility of the patient/guarantor.

MEDICARE RECIPIENTS: Your fees for this surgical care may not be covered by Medicare by law. We will file claims for you where appropriate. All charges are your own responsibility.

ASSIGNMENT: I hereby authorize payment directly to the oral surgeon of benefits due me for this service.

RELEASE: I authorize the oral surgeon to release any information regarding my examination and treatment to my insurance company/HMO, dentist, or primary physician.

NOTICE

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artifcial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree to the forms of contract described above.

_____ _____

Patient/Guardian Signature Date

Anyone having questions about our financial policy or needing special arrangements should contact our billing office.

I have read the above information and agree to comply with the financial policy of West Michigan Oral and Maxillofacial Surgery, P.C.

Signature of **Patient**, if 18 or older	Driver's License #	Date
Signature of **Parent**, if patient is a minor	Driver's License #	Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
WEST MICHIGAN ORAL SURGERY

601 Michigan Ave, Suite 200, Holland MI 49423	**12350 Riley Street, Holland MI 49424**
4330 44th Street S.W. Suite 106, Grandville MI 49418	**919 South Beechtree Suite 8, Grand Haven MI 49417**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician Certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Keeping current with the Privacy Rule defined in HIPAA guidelines, we are now requesting your written consent for each person(s) that we are allowed to share your Protected Health Information with. Please list the individual(s) below and to be sure to notify us if this information changes.

1._____ _____ _____
Authorized Individual/Person Relationship Date

2._____ _____ _____
Authorized Individual/Person Relationship Date

3._____ _____ _____
Authorized Individual/Person Relationship Date

Patient Name _____

Signature and Print Name _____
(Of patient or legal guardian if a minor)

Relationship to Patient _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

WEST MICHIGAN
Oral & Maxillofacial Surgery

CANCELLATION / NO SHOW POLICY

To our patient,

West Michigan Oral Surgery prides itself in providing the best care to our patients. Our office holds valuable time and resources aside for our patient's appointments. As a mutual understanding, we request our patients be respectful of our time and the commitment we have made.

In order to care for, and be available to our West Michigan patients, we have implemented a cancellation/no show policy as listed below.

A $100 fee will be charged to you if any of the following occur:

1. You do not provide 48 business hours' notice if you are unable to keep your appointment
2. You fail to show up for your appointment
3. You fail to follow your pre-operative surgical instructions

In order to reschedule your surgery, the following will apply:

1. Friday appointments will not be available
2. The cost of your procedure plus the $100 fee must be paid prior to rescheduling the appointment

Cancellations MUST be made during normal business hours, Monday – Friday 8 AM – 5 PM.

_____ _____

Signature of patient/guardian Date