

REGISTRATION FORM

PLEASE complete and email and/or bring forms with you to your appointment

PLEASE PRINT

DATE _____

NAME _____ AGE _____ BIRTHDATE _____

SOCIAL SECURITY # _____ SEX _____ HEIGHT _____ WEIGHT _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ MARITAL STATUS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL ADDRESS _____

REFERRED BY _____ FAMILY DENTIST _____

FAMILY M.D. _____ M.D PHONE # _____

PHARMACY NAME _____ PHARMACY PHONE # _____

OCCUPATION _____ EMPLOYED BY _____

IF STUDENT, NAME OF SCHOOL _____

NAME OF PARENT/SPOUSE _____

ADDRESS (IF DIFFERENT) _____

HOME PHONE _____ WORK PHONE _____

EMERGENCY CONTACT NAME/RELATION/PHONE# _____

INSURANCE -- MEDICAL _____ GROUP# _____

INSURED NAME _____ ADDRESS _____

INSURED BIRTHDATE _____ ID or SS# _____

INSURANCE -- DENTAL _____ GROUP# _____

INSURED NAME _____ ADDRESS _____

INSURED BIRTHDATE _____ ID or SS# _____

PERSON RESPONSIBLE FOR ACCOUNT _____

METHOD OF PAYMENT: CREDIT/DEBIT CARD CHECK CASH (CIRCLE ONE)

PLEASE CONTINUE TO NEXT PAGES

MEDICAL HISTORY QUESTIONNAIRE

NAME _____ DATE _____

❖ *In the following questions please **CIRCLE** yes or no, whichever applies. your answers are for our records only and will be considered confidential.*

1. **YES NO** Are you in good health? _____

2. **YES NO** Has there been any change in your general health in the past year? _____

My last physical exam was on _____

3. **YES NO** Are you now under the care of a physician? _____

If so, what is the condition being treated? _____

The name and address of my physician: _____

4. **YES NO** Are you taking **ANY MEDICATION** including non-prescription medication? **If yes please list:**

5. **YES NO** Do you take or have ever taken **Bisphosphonates** for Osteoporosis or any Cancer?

(E.g. Fosamax, Zometa, Boniva, Actonel, Reclast, Aredia, Prolia, Avastin)

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

6. **YES NO** Heart problems (High Blood Pressure, Heart Murmurs, Congestive Heart Failure, Heart Attack, etc.)

If Yes, Please list below:

7. **YES NO** ASTHMA? If yes, do you use an inhaler? **YES/NO**, and when was your last attack?

8. **YES NO** Respiratory problems, emphysema, bronchitis, etc.? **If yes, what?**

9. **YES NO** Central Nervous System, BRAIN (Stroke, TIA, etc.)? **If yes, what?**

10. **YES NO** DIABETES? If yes, circle **Insulin Injections** or **pills**.

Your last *Blood Sugar* reading was _____

11. **YES NO** Liver Disease?

12. **YES NO** AIDS/HIV infection or any sexually transmitted diseases? **If yes, what?**

13. **YES NO** Thyroid problems? **If yes, what?**

14. **YES NO** Stomach ulcer or hyperacidity? **If yes, what?**

15. **YES NO** Kidney Trouble? **If yes, what?**

16. **YES NO** Have you had abnormal bleeding, required a blood transfusion or anemia? **If yes, why?**

17. **YES NO** Do you smoke? **If yes, how often?**

18. **YES NO** Do you drink alcohol? **If yes, how often?**

19. YES NO Do you use recreational drugs? If yes, please list. _____

20. YES NO Do you have any Prosthetics? (hip, knee replacement)

PLEASE LIST ANY OTHER MEDICAL CONDITIONS:

21. YES NO Have you had any past surgeries in a Hospital? If yes, please list including date(s).

ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

22. YES NO Local anesthetics?

23. YES NO General anesthesia?

24. YES NO PENICILLIN, Sulfa or other ANTIBIOTICS? If so what?

25. YES NO Barbiturates, sedatives, or sleeping pills, soybeans or eggs? If yes, please specify _____

26. YES NO Iodine?

27. YES NO LATEX?

28. YES NO Aspirin, codeine, or other narcotics? If so, what? _____

29. YES NO Have you had any serious trouble associated with any previous dental treatment? If so explain?

30. YES NO Have you had any disease, condition, or problem not listed above that you think I should know about?

31. YES NO HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE PAST 8 HOURS?

WOMEN

1. YES NO Are you PREGNANT or any chance of being pregnant?

2. YES NO Are you NURSING?

3. YES NO Do you have any problems associated with your menstrual period?

4. YES NO Are you taking birth control pills, or other hormonal therapy?

ORAL CONTRACEPTIVES MAY BE RENDERED LESS EFFECTIVE WHEN TAKEN CONCURRENTLY WITH ANTIBIOTICS. IT IS ADVISABLE TO USE ADDITIONAL FORMS OF BIRTH CONTROL WHEN TAKING ANTIBIOTICS.

Reason for today's visit _____

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

SIGNATURE OF PATIENT/PARENT/GUARDIAN

DATE

Office Financial Policy

Our fees are meant to be fair and reasonable. To make payments convenient for you, we accept cash, personal and business checks, Visa, Discover, Master Card, American Express, and Care Credit. ***Payments are due at the time services are rendered, and patients not having any insurance are expected to pay in full the day of service unless a payment plan has been prearranged for larger cases.*** Please discuss any issues with the front that this may cause before being seen.

Insured patients should become familiar with the benefits and limitations of their plan. If your insurance needs a referral for coverage, it is your responsibility to bring one before surgery or you will be responsible for payment of the services rendered. If your plan has a Maximum or Cap, insurance will pay no more once the maximum has been met, expecting the remainder to become the insured's responsibility. There is a chance your insurance may not cover the services rendered. You are ultimately responsible for your bill, subject to your insurance policy's coverage.

If your account is turned over to our collection service because of non-payment, a collection fee will be added to cover their charge to us for recovery, based as follows: 25% over \$500 balance; 35% for a \$100 up to \$500 balance; and 50% up to \$100 balance. Any checks returned to our office due to insufficient funds are subject to an additional fee of \$25.00. Immediate remittance in the form of cash, money order or certified funds is expected.

If at any time you have a question about this policy or your account, please do not hesitate to contact our office. (301)926-4800.

*****DISCLAIMER*** ANY QUOTE OF BENEFITS OR MONEY PAID DAY OF SURGERY IS AN ESTIMATE, *NOT A GUARANTEED AMOUNT*. THE MONEY IS A DOWN PAYMENT TO BE CORRECTED ONCE INSURANCE TELLS OUR OFFICE THE DEFINITE AMOUNT THE PATIENT IS EXPECTED TO PAY. Any difference according to the insurance explanation of benefits will be billed or refunded to the patient after the insurance payment has been received.**

I authorize release of information needed to process my claim and assign insurance benefits.

HIPAA: I UNDERSTAND THE OFFICE FOLLOWS HIPAA REQUIREMENTS GUIDELINES.

I HAVE READ THE ABOVE POLICY AND AGREE BY SIGNING BELOW TO ACCEPT FINANCIAL RESPONSIBILITY FOR THE TREATMENT GIVEN BY THIS OFFICE PER MY INSURANCE

PATIENT NAME _____ DATE _____

SIGNATURE: PERSON RESPONSIBLE FOR BILL _____

IF OVERPAID, REFUND CHECK SHOULD BE ISSUED TO: _____

Welcome to Integrative Oral and Facial Surgery

Office of Dr. Jay S. Nokkeo, DMD, Dr. H. Iwin Chu, DMD, Dr. Jason Marrazzo, DDS, and Ziad A. Ali, DMD. MD

HOW DID YOU FIND US?

Please Check

- Direct Referral from another Dentist/Doctor
- Direct Referral from Family/Friend
- Hard Copy Phone Book/Yellow Pages
- Insurance
- Self / Walk in

INTERNET/ON-LINE (please check)

- Google
 - Google Search
 - Google Maps
 - Google+
 - Google Blogs
- Yahoo/Bing/Other Search Engine
- Yelp
- Facebook
- LinkedIn
- Craig's List
- Angie's List
- Other Internet Media (please list)

Thanks for your response!