INTEGRATIVE
ORAL & FACIAL SURGERY

Consent to treat amid the COVID-19 Pandemic.

During these times of COVID-19, we want to do all we can to minimize the risk of infection spread.

While the risk of transmission is very low and risk of serious life threatening complications remains very low in the young and healthy, we understand there is still a risk. With that said, we would like you to answer a few questions before we treat you.

Questionnaire: **PLEASE CIRCLE YES OR NO BELOW**

1. Do you have any of the following signs or symptoms:
   Fever, Cough, runny nose, headaches. loss of taste and smell.....YES/NO

2. Have you had recent contact with anyone who has had these symptoms within the last few weeks?.....YES/NO

3. Have you had contact with anyone who has traveled abroad recently?.....YES/NO

4. Do you have any medically compromised condition which may make you more prone to not responding well to exposure to COVID -19?.....YES/NO

We understand this is an inconvenience, but we have to do our part to ensure we do our part to prevent the transmission of COVID 19 to our staff, other patients and our families. By signing below, you agree to consent to treatment.

_____	_____	_____
Patient/Guardian Print Name	Signature	Date

Thanks you in advance for your understanding.

Integrative Oral and Facial Surgery.
Jay S. Nokkeo, DMD

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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 _____

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 _____

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, Master Card. ***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 $1000 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: _____

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Integrative Oral & Facial Surgery

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 Please circle

Google : Google Search Google Maps Google + Google Blogs

☐ Yahoo/Bing/Other Search Engine

☐ Yelp

☐ Linkedin

☐ Craig's List

☐ Angie's List

☐ Other Internet Media (please list)_____

Thanks for your response.

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