HADDON ORAL AND MAXILLOFACIAL SURGEONS

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Moorestown, NJ 08057
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DATE: _____

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑Male ❑Female Date of Birth _____ / _____ / _____ Age _____ Social Security # _____ - _____ - _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell# (_____) _____ Employer _____ # _____

Family Dentist _____ Referred By _____

Have you ever been a patient of our practice prior to this visit? ❑ Yes ❑No Email _____

Who will be responsible for your account: **Cell # (_____)** _____

Name _____ **Soc.Sec#** _____ - _____ - _____ **Home Tel. (_____)** _____

Street _____ City _____ State _____ Zip _____

DOB _____ Employer _____ **Tel. (_____)** _____

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name _____

Subcriber to Ins. _____ **Relation to Patient** _____

Sex: ❑Male ❑Female Subscriber DOB _____

SS of Subscriber _____

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name _____

Subcriber to Ins. _____ **Relation to Patient** _____

Sex: ❑Male ❑Female Subscriber DOB _____

SS of Subscriber _____

Insurance: To avoid misunderstanding regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees.

Agreement to pay: I agree to be personally responsible for the payment of all services rendered on my behalf. In the event a quotation of fees is not given to me before the services being performed, I shall ask for such quotation or waive my right to later claim the fee exceeding the value of the services rendered. In the event that payment for dental services is not made within thirty days of treatment, then interest at the legal prevailing rate plus a service charge may be added to the past due balance.

Date: _____ Patient's Signature: _____
Parent or guardian if patient is a minor.

Date: _____ Patient's Signature: _____
Parent or guardian if patient is a minor.

Date: _____ Patient's Signature: _____
Parent or guardian if patient is a minor.

Patient Name	MEDICAL HISTORY
Patient Account No.	

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If Yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State ____ Zip _____
2. Are you taking any medication, drugs, pills or herbal supplements now? Yes No
   (If Yes, list) _____
   _____
3. Are you aware of having an allergic **(or adverse reaction)** to any medication, substance, eggs or soy? Yes No
   If yes, please list: _____
4. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) Yes No	Thyroid Problems Yes No	Immune System Disease Yes No
Chest Pain Yes No	Unexplained weight change	Cold Sores/Fever Blisters Yes No
Congenital Heart Disease Yes No	within last year Yes No	Blood Transfusion Yes No
Heart Murmur Yes No	Glaucoma Yes No	Bleeding Disorder Yes No
High Blood Pressure Yes No	Contact lenses Yes No	Sickle Cell Disease Yes No
Mitral Valve Prolapse Yes No	Emphysema/COPD Yes No	Bruise Easily Yes No
Artificial Heart Valve Yes No	Chronic Cough/Bronchitis Yes No	Liver Disease Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Yellow Jaundice Yes No
Rheumatic Fever Yes No	Asthma Yes No	Neurological Disorders Yes No
Prosthetic Joints Yes No	Hay Fever Yes No	Epilepsy or Seizures Yes No
What Joint _____	Latex Sensitivity Yes No	Fainting or Dizzy Spells Yes No
Arthritis Yes No	Sinus Trouble Yes No	Nervous/Anxious Yes No
Taking Cortisone Medicine Yes No	Radiation Therapy Yes No	Psychiatric/Psychological Care Yes No
Swollen Ankles Yes No	Chemotherapy Yes No	Chronic Fatigue Yes No
Stroke Yes No	Tumors Yes No	History of Drug Abuse Yes No
Diet (Special/Restricted) Yes No	Any other Lung Disease Yes No	Sleep Apnea Yes No
Kidney Trouble Yes No	Smoke Yes No	Blood Thinners
Hypoglycemia (Low Blood Sugar) Yes No	Problems with Healing Yes No	i.e. Aspirin, Plavix, Coumadin Yes No
Diabetes Yes No	Hepatitis Yes No	Ulcers (Stomach) Yes No
Sexually Transmitted Diseases Yes No		

5. Do you have or have you had any disease, conditions, or problem not listed Yes No
   If yes, please list _____
   Height _____ Weight _____
6. **Women.** Are You: **Pregnant?** Yes, ____ Months No _____ **Nursing?** Yes No **Taking birth control pills?** Yes No
6a. Are you taking medication for Osteoporosis? ❑ Yes ❑ No (i.e. Fosamax, Boniva, Zometa, Prolia, Reclast)
7. Have you had general anesthesia? Yes No
   If yes, for what reason _____
   Complications ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Parent/Guardian Signature _____ Date _____

Patient/Parent/Guardian Signature _____ Date _____

Patient/Parent/Guardian Signature _____ Date _____

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FINANCIAL POLICY

Please be aware of our financial policy in order to avoid possible misunderstandings or difficulties at a later date.

*If you have no verifiable insurance coverage, payment in full is expected at time of service.

* Your insurance co-pay is due at time of service. *Please be aware insurance is a contract between you and your insurance company. We are not a party to this contract. We have no way of knowing what services your employer may have included or excluded in your coverage. We, as a courtesy to you, will bill your insurance carrier: however your insurance company makes the final determination as to your eligibility, amount they will pay, and your copay. This means you agree to pay any portion of the charges not paid for by insurance after contractual adjustments (if any).*

* The balance of your account is ultimately your responsibility whether your insurance company pays or not.

*Unpaid accounts more than 60 days old may be referred to collections, and the patient will be billed for all collection costs. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all cost, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

As always, we value our patients. Providing the best care possible is our primary goal.

Your signature signifies you agree to all of the terms and conditions contained herein and this agreement will be in force and effect.

SIGNATURE _____ **DATE** _____**DATE**_____

PRINT NAME _____ **DATE**_____**DATE**_____

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