Central Virginia Oral & Facial Surgery

Welcome to our office. Please provide us with the information requested below. Insured patients are urged to provide us with all the necessary information in order for us to properly assist you with your claims. All information is kept confidential.

PATIENT INFORMATION (Please Print Clearly) **Today's Date: _____**

Patient Name: _____ Age:_____ Date of Birth: _____

Patient Address: _____ Social Security #: _____

City: _____ State: _____ Zip:_____ Home Phone: (____)_____ Cell: (_____)_____

Employer: _____ Work Phone: (____)_____

Marital Status: □Married □Single **Relationship to insured:** □Self □_____

Sex: □Male □Female ***** E-Mail Address_____*****

GUARANTOR (party responsible for patient under 18 years) or INSURED'S INFORMATION (person carrying insurance plan)

Insured/Responsible Party's Name: _____ Date of Birth: _____

Responsible Party's Address: _____ Social Security #: _____

City: _____ State: _____ Zip:_____ Home Phone: (____)_____ Cell: (_____)_____

Employment Status: □ Full-Time □ Part-Time □ Unemployed □Retired

Employer: _____ Work Phone: (____)_____

Insurance: **Medical:** _____ **Medicare?** □Yes □No **Dental**: _____ **Medicaid?** □Yes □No

- We are enrolled with **Medicaid, if you have Medicaid please list it as insurance.**
- Currently, we are **not** enrolled with **Medicare**. If you have **Medicare**, please read and sign the form included with this packet.
- We are **only** "participating providers" (In-network providers) for **Anthem, Cigna, PCHP, MetLife and Delta Dental Insurance**.
- As a courtesy to our patients, we will file claims to your insurance, **it is important you provide us with the proper information**.

I understand and agree to the following statements:

1. **If this is my initial visit, there will be a fee for the consultation and any x-rays deemed necessary by the Doctor.**
2. All returned checks will be subject to a **$50.00** service charge.
3. **Estimated financial responsibility for services is due in full at the time services are rendered.**
4. **Regardless of my insurance status, I am solely responsible for any balance due on my account for professional services performed. Claims submitted are not a guarantee of payment. I understand fees are calculated based on an estimate.**
5. This office **will not** change the code of a procedure in order to get your insurance to pay. Regardless of what your insurance representative may tell you.
6. I agree to inform the office of any changes in my health status or the above information.
7. **I agree to pay all legal and attorney fees if legal action is needed to collect any unpaid overdue balances, including collection agency fees. A processing fee of 1.5% of the balance may be charged monthly for unpaid balances.**
8. The office may apply a **$50.00** service charge for a missed appointment if not notified within 24 hours, unless an emergency occurred.
9. I certify that, to the best of my knowledge, the above information is true and correct.
10. I agree for my image (*still and video*)/dependents image (*still and video*) to be used for my/their medical record and for teaching purposes. **I understand I will not receive payment from any party**.

I agree to the release of any medical information needed to prepare my insurance forms.
I consent to the payment of benefits to Dr. William Carvajal, Dr. John Pinch, Dr. Evan Chalk and Dr. Michael Richmond.
A copy of this consent form is as acceptable as the original.
I have seen the posted copy of this office's Notice of Privacy Practices, and I may request a copy at any time.

Signature: _____Date: _____

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The purpose of this form is to assist you in understanding our office policies

Insurance:

Please provide the front desk with insurance cards (both medical and dental), and your social security number (enables us to properly submit your claim). If said information is not provided and we are unable to properly assist you in producing and submitting a claim, the full amount will be your responsibility as will submitting your own claim. **As a courtesy to our patients, we file the insurance claims. Please note that the financial obligations for services rendered are your responsibility, regardless if you have insurance.** At the conclusion of your initial visit you will be given an **estimate** of your anticipated portion, that **estimated** portion is due the day of the procedure. **Please note that this is not a guarantee the amount paid is the extent of your financial responsibility, it is the amount collected in good faith based on the estimated portion of insurance involvement.** If there is a balance after insurance payment, you will be billed on the next billing cycle after insurance payments are posted, and that balance is due upon receipt of statement. Please review all correspondence sent from our office because you may owe a small balance after insurance and on rare occasions be in receipt of a refund check due to the insurance payment being greater that the estimated amount. **Most insurance will not pay for the entire cost of care.** Your policy may have a list of limitations/exclusions, a co-payment provision, annual deductible and an annual maximum dollar amount. **It is the patient's responsibility to know their insurance benefits and limitations of coverage.** We will do everything possible to assist you in producing and submitting the claims for services, insurance plans vary considerably, and nothing is guaranteed until final insurance payment is posted to your account**. Your signature below signifies understanding of the above as well as grants us permission to contact your insurance company to verify coverage and limitations, so that we can better assist you in filing claims and determining patient and insurance responsibility.**

Financial Arrangements: Estimated patient responsibility is due at the time services are rendered. We accept cash, check, and major credit cards. We also accept *CareCredit* for payment, this service allows you to start treatment today and spread payments over time. This is a line a line of credit that offers interest free options and is subject to credit approval. Simply go to *carecredit.com* or call 877-905-2097. In most cases a decision is rendered instantly, and a card # and purchase limit are produced at that time. Simply print that information and provide a copy to us and we can offer you the deferred payment terms.

Please be informed that if at any time we carry a balance on your account, it will be subject to a monthly finance charge of 1.5% of the unpaid balance. If you do not contact our office to discuss payment options and balance goes unpaid, it will be turned over to an outside collection agency and additional collection agency fees will be applied.

HIPAA: Your privacy is important to us, to prevent a breakdown in communication please fill out the form that lists individuals we may discuss your account with.

Medicare: Our Doctors do not participate with Medicare, we cannot file claims to them, nor can you.

Signature: _____ Date: _____

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Patient Record of Disclosure

Patient Name: _____ Date: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information. The individual also has the right to request confidential communication of their protected health information.

I wish to be contacted in the following manner: (Check all that apply)

□ Home Telephone#_____ OK to leave message? _____

□ Work Telephone#_____ OK to leave message? _____

□ Written Correspondence OK to mail to home? _____

□ E-mail_____ OK to send E-mail? _____

□ I give permission for my protected health information to be shared with: (please list spouse, family members, friends, or any other person that may help with your healthcare needs)

Please list the person or persons that will accompany you on the day of procedure.

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken.

Signature: _____ **Date: _____**

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Information for current Primary Care Physician OR Specialist

Patient Name: _____

Date of Birth: _____

I, *(patient name)* _____ give permission for

Dr._____

to release copies of my medical records to the Doctors of Central Virginia Oral & Facial Surgery.

Printed Name: _____

Signature_____

Date: _____

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Patient's Name _____ Date: _____ Chart# _____

1. Has there been any change in your medical history within the past year? Y N
   My last medical examination was on_____(date)

2. Are you under the care of a physician? Y N
   If yes, what is the condition you are being treated for_____

3. The name and address of my physician is: _____
   _____

4. Have you ever been hospitalized for any serious illness or operation? Y N
   If yes, please explain_____

5. Do you have, or have you had, any of the following diseases or problems?

- Rheumatic fever or rheumatic heart disease Y N
- Heart murmur Y N
- Congenital heart defects Y N
- High blood pressure Y N
- Heart disease, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke Y N
- Do you have pain in your chest upon exertion? Y N
- Do you snore or use a CPAP machine at night? Y N
- Have you ever been diagnosed, treated, or evaluated for sleep apnea? Y N
- After mild exercise, do you have shortness of breath? Y N
- Do your ankles swell? Y N
- Do you get shortness of breath when you lie down, or do you require extra pillows when you sleep? Y N
- fainting spells or seizures Y N
- stomach ulcers Y N
- kidney trouble Y N
- any recent unexpected weight loss Y N
- Any recent night sweats or fever Y N
- Do you have a persistent cough and/or cough up blood? Y N
- Asthma or hay fever Y N
- Hives or skin rash Y N
- Diabetes Y N
- hepatitis, jaundice, or liver disease Y N
- Have you ever received blood products, transfusions, kidney dialysis or hemodialysis? Y N
- Has your blood ever been refused for donation to a blood bank? Y N
- Arthritis Y N
- Joint replacement Y N
- Sexually transmitted disease Y N
- Gonorrhea, syphilis, herpes Y N

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- Do you have a bleeding disorder? Y N
- Have you had any abnormal bleeding associated with previous tooth extractions, surgery, or trauma? Y N
- Do you bruise easily? Y N
- Have you ever required a blood transfusion? Y N
  - If yes, please explain_____
- Do you have any blood disorders such as anemia? Y N
- Have you ever had chemotherapy or radiation? Y N
  - If yes, please explain_____

6. Have you had any previous surgery? Y N
   List Surgeries: _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____

7. Are you currently taking any medications? Y N
   List medications: _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____

8. Are you taking, or have you taken steroids within the last two years? Y N

9. Are you taking, or have you taken any bisphosphonate drugs (Fosamax, Actonel, Boniva, etc.) for osteoporosis or any other reason. Y N

9. Are you allergic or have you reacted adversely to:
   - Local anesthetics Y N
   - Penicillin or other antibiotics Y N
   - Barbiturates, sedatives or sleeping pills Y N
   - Aspirin Y N
   - Iodine Y N
   - Codeine or another narcotics Y N
   - Latex Y N
   - other_____ Y N

10. Do you smoke? Y N

11. Do you use smokeless tobacco? Y N

12. How much alcohol do you consume per day? _____

13. Have you ever been in a drug or substance rehabilitation program? Y N

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14. Are you pregnant? Y N

15. Do you have any disease, condition, or problem not listed above? Y N

    If yes, please explain_____

16. What is your chief complaint (reason for being here) _____

17. When was your last dental visit: _____

18. Name your dentist: _____

19. Who referred you here to our office? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature: _____ Date: _____

DOCTORS NOTES:

Ht:

Wt:

PMHX

BMI:

PSHX

BP:

P:

MEDICATIONS

ALLERGIES

SOCIAL HX

DOCTOR'S SIGNATURE: _____ DATE: _____

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ATTENTION:

PATIENTS WITH MEDICARE AND MEDICARE SUPPLEMENT

The purpose of this advance notice is to help you make an informed choice about whether you want to receive treatment at this facility. **William Carvajal, D.D.S., M.D., Evan Chalk, D.M.D and John Pinch, D.D.S. are not enrolled in the Medicare program.**

By signing this form, you as the Medicare beneficiary, or your legal representative agrees to the following:

1. You agree not to submit a claim or to request the physician or practitioner to submit a claim for payment under Medicare, *even if such items and services would otherwise be covered by Medicare.

2. You acknowledge that Medigap Plans will not pay towards the services and other supplemental insurers may choose not to make payment for items and services furnished by the physician or practitioner under this contract.

3. You agree to be responsible for payment for such items and services.

4. You acknowledge that no reimbursement will be provided by Medicare for such items and services, including laboratory testing, provided to you.

5. You acknowledge that the physician or practitioner is not limited in the amount he or she may charge the beneficiary for the items and services provided to you.

6. You acknowledge that you have the right to receive services from other physicians or practitioners from whom Medicare coverage and payment would be available for medically necessary procedures.

7. You agree that the services you are requesting do not constitute an emergency or an urgent healthcare situation.

The Medicare program **does not cover services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth.*

Name *(Printed):* _____

Signature: _____

Date: _____