Welcome to our Practice

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. #_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME) _____ (LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME) Medical Dr._____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.#_____ Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(_____)_____

Employer_____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact_____ (FIRST NAME) _____ (LAST NAME) Tel. (_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age_____

Tel.(_____)_____ Cell. (_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street_____ Apt._____ City_____ State_____ Zip_____

Tel. (_____)_____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 64–67)*

		Yes	No
64.	Is there a possibility of pregnancy?	❑	❑
65.	Expected delivery date? _____		
66.	Are you nursing?	❑	❑
67.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
68. Any kind of medication, drug, pills?			
69. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
70. Have you ever taken diet pills?			
71. Any natural product, herbal supplement or homeopathic remedy?			
72. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, or Reclast in the past 12 years?			

73. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

74. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
75. Local anesthetic (numbing meds.)?			
76. Penicillin?			
77. Other antibiotics?			
78. Sulfa drugs?			
79. Sodium pentothal / Valium / other tranquilizers?			
80. Aspirin?			
81. Amoxicillin?			
82. Codeine or other narcotics?			
83. Other medications?			
84. Latex?			
85. Soy?			
86. Eggs / yolk?			
87. Sulfites?			
88. Do you have any known allergies?			

89. Please list any allergies other than drug allergies:

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

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

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date** X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)* X _____ **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Witness** X _____ **Doctor** X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

GEORGETOWN ORAL SURGERY
Richard M. Williams, D.D.S.
Kenneth Goldblatt, D.D.S.
Kalpakam A. Shastri, D.D.S.
Ronald Brown D.D.S. MS

ORAL AND MAXILLOFACIAL SURGERY
JAW SURGERY * IMPLANTS * TRAUMA * EXTRACTIONS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME (PLEASE PRINT)**:** _____
Please read the following statements carefully:
By signing this form, you will consent to our use and disclosure of your protected health information in order to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide to sign this consent form. This document provides a description of our treatment plan, payment activities, and healthcare operations, which require the use and disclosure of your protected health information. You may find a copy of the said document in your New Patient packet. We encourage you to read it thoroughly before signing this document. Also, you may obtain a copy of our Notice of Privacy Practices, including any recent revisions, at any time by contacting our office:

Dr. Richard M. Williams, DDS
Phone: (202) 364-9400
Fax: (202) 364-1511
Email: WilliamsOS@aol.com

Right to Revoke: You may revoke this contract anytime by submitting a written notice of your intent addressed to Dr. Richard M. Williams, using the contact information listed above. Please be mindful that your revocation of consent does not impact our handling of your health information prior to receiving this notice. In addition, we may decline to accept you as a new patient or continue your treatment if you refuse or revoke your consent for disclosure of health information.

After reading the statement above, please complete the following:

I, _____ have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that by signing this form, I am giving my consent for the use and disclosure of my protected health information, for the purposes of carrying out treatment, payment activities, and health care operations.

Patient Signature _____ Date _____

If you're signing on behalf of the patient, please complete the following:

Name (Please Print) _____ Relationship to patient _____

Representative's Signature _____ Date _____

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RELEASE OF INFORMATION POLICY

PATIENT NAME (PLEASE PRINT)**:** _____

Please read the following statements carefully and initial in the space provided:

_____ I understand that HIPPA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing Dr. Richard M. Williams, Dr. Kenneth Goldblatt, or Dr. Kalpakam Shastri in writing.

_____ Regarding home or cellular telephone numbers: We may leave a message with a callback number regarding administrative, scheduling or patient-care related issues, and leave reminders for your upcoming appointments on voicemail.

_____ Regarding work telephone number: We may leave a message with a callback number regarding administrative, scheduling or patient-care related issues, and leave reminders for your upcoming appointments on voicemail.

_____ Regarding written communication: We may mail postcards to your home address or send you emails if applicable.

Patient Signature _____ Date _____

Georgetown Oral Surgery
4400 Jenifer St, Suite 270
Washington DC 20015

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APPOINTMENT CANCELLATION POLICY

PATIENT NAME (PLEASE PRINT)**:** _____

- Dr. Williams, Dr. Goldblatt, Dr. Shastri, Dr. Brown and staff are committed to providing each patient with excellent care and service. In doing so, we ask that each patient be aware of our policies and procedures. In our effort to better serve your needs, we do not double book any appointments. Each appointment is reserved exclusively for one patient. We do our best to make sure that each patient is seen on time and receives the care and attentions that they deserve. To keep us on schedule we ask that patients arrive 15 minutes before their appointment is scheduled to begin.
- We request that in the event of a need to cancel an appointment, you do so in no less than 24 hours before your appointment time. This courtesy allows us to offer this appointment to another patient in a timely manner. If the appointment is cancelled in less than 24 hours, arrived late for, or missed entirely, the patient will be charged a fee of $50.00 per half hour of scheduled time.
- This policy is designed to be a deterrent for last minute cancellations, as they are an inconvenience to our staff and other patients. We attempt to limit such incidents by supplying appointment cards when possible and confirming your appointment by telephone two business days before. If you have any questions regarding our office policy, please do not hesitate to ask.

Patient Signature _____ Date _____

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FINANCIAL POLICY FOR OFFICE

PATIENT NAME (PLEASE PRINT)**:** _____

We offer our patients the following methods of payment. Please check the options you wish to use:

( ) Patients may pay in cash or by check
( ) Patients may pay with Visa or MasterCard, American Express, and Discover

Our front office staff will be filing your insurance claims. However in cases where the procedure fee is not partially or fully covered by the patient's insurance provider, the guarantor of the account is ultimately responsible to pay the overdue balance.

In the case that you are in default, we reserve the right to add an additional 30% to your balance for collection and attorney's fees. Eighteen percent (18%) annual interest charge will be assessed on account balances not paid in full 60 days after sending you a third written notice. All returned checks are subject to a $25.00 bounced check fee.

Signature of Patient _____ Date _____
Signature of person responsible for financial obligations_____ Date _____

INFORMATION REGARDING DENTAL AND MEDICAL INSURANCE

It is important for you to be informed that if you are covered by a Dental or Medical insurance (even in the event of an accident), our professional services are rendered and charged to you, not the insurance company. Some insurance programs require us to collect a referral form, you must present this form upon arrival or you will be responsible for full payment of services rendered at the end of your appointment.

Our services are offered on the basis that you will pay full charges. Most insurance coverage pays only a portion of the cost of such services that may be necessary.

You will be assisted in preparing necessary forms for your insurance claims. It may be necessary for you to provide the forms. You can obtain forms from your insurance company, place of business or union.

Some health insurance programs provide limited coverage for Oral and Maxillofacial surgery. Some provide no coverage. Very few cover the full charges. We urge you to be fully aware of the provisions of your policy. We require 48 hours' notice of changes in insurance plans or benefits prior to appointments.

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