ORAL SURGERY CENTER, S.C.

Dr. Steve Anderson
1203 8th Street
Baraboo, WI 53913
608-356-2112
info@oscbaraboo.com

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

E-mail Address _____

Employer _____ Employer Phone #_____

Parent or Guarantor Information (if Patient is a minor)

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

E-mail Address _____

Employer _____ Employer Phone #_____

Spouse or Other Guarantor Information

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

E-mail Address _____

Employer _____ Employer Phone #_____

PLEASE CHECK ALL THAT APPLY

Marital Status:
___ Single
___ Married
___ Legally Separated
___ Divorced
___ Widowed

Employment Status:
___ Full-Time
___ Part-Time
___ Retired
___ Work Visa

Student Status:
___ Full-Time
___ Part-Time
___ Student Visa

HIPAA ACKNOWLEDGEMENT AND CONSENT

The Oral Surgery Center, a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization. I hereby authorize The Oral Surgery Center to disclose all health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules create in HIPPA. This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by The Oral Surgery Center.

PERSON'S AUTHORIZED TO RECEIVE MY PROTECTED HEALTHCARE INFORMATION

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I acknowledge that I have received and read the Oral Surgery Center's HIPAA Notice of Privacy Practices. The Oral Surgery Center has my permission to share/release my protected healthcare information to the person(s) listed above.

_____ _____

Signature Date

INSURANCE INFORMATION

As a courtesy, we will bill two dental & two medical insurance companies that we accept for you. If you have additional insurance policies, you are responsible for billing them.

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company:	Insurance Company:
Employer:	Employer:
Subscriber's Name: Same as patient's ☐	Subscriber's Name: Same as patient's ☐
Relationship to Patient:	Relationship to Patient:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's SS # : **(Required to bill insurance)**	Subscriber's SS #: **(Required to bill insurance)**
Subscriber's Address: Same as patient's ☐	Subscriber's Address: Same as patient's ☐
Subscriber's Phone #:	Subscriber's Phone #

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Insurance Company:	Insurance Company:
Employer:	Employer:
Subscriber's Name: Same as patient's ☐	Subscriber's Name: Same as patient's ☐
Relationship to Patient:	Relationship to Patient:
Subscriber's Date of Birth:	Subscriber's Date of Birth:
Subscriber's SS #: **(Required to bill insurance)**	Subscriber's SS #: **(Required to bill insurance)**
Subscriber's Address: Same as patient's ☐	Subscriber's Address: Same as patient's ☐
Subscriber's Phone #	Subscriber's Phone #

Is this visit related to an accident? _____ Date of Accident _____

If yes, please explain_____

_____

Insurance Co./Adjustor handling this claim_____

Contact Information: Phone #_____ E-mail: _____

I hereby certify that the information that I have disclosed is accurate and true to the best of my knowledge. I understand that I am financially responsible for payment of all services rendered on my behalf or on behalf of my dependents . By signing this form I authorize my insurance companies to assign benefits payable to The Oral Surgery Center.

Signature **Date**

ORAL SURGERY CENTER, S.C.
Financial Policy

Insurance: We will submit a claim to your insurance on your behalf. However, we must have a current copy of BOTH medical and dental insurance cards at the time of your appointment. We will bill up to 2 dental and 2 medical insurance carriers (that we accept) for you. If you are unable to provide us with the cards and/or the information to accurately submit to your insurance, you will be considered a self-pay patient.

Your insurance policy is a contract between you and the insurance company; we are not a party to that contract at any time and do not have the authority to make the insurance company pay. We do encourage you to contact your insurance company with any questions.

You are responsible for all charges incurred, regardless of insurance coverage. It is your responsibility to see that the insurance pays for your services in a timely manner. Any and all co-pays, deductibles and co-insurances are due at the time of service.

We are In-Network Providers for Quartz, Dean and GHC.

Blue Cross Blue Shield & United Healthcare: The Oral Surgery Center, S.C. does NOT accept Blue Cross Blue Shield or United Healthcare. You will be considered a self-pay patient and will be required to pay for your services in full. We will give you a printout of services provided and you will be responsible to file all claims on your own.

Self-Pay Patients: Payment is due on the day services are rendered. The Oral Surgery Center, S.C. accepts payment in the form of cash, check, Visa, MasterCard, Discover, Care Credit and Cherry. Care Credit is a line of credit for medical and dental care. An application may be obtained at our office or at www.carecredit.com. Cherry is a line of credit for the Oral Surgery Center only. Ask us for more information.

Surgery Deposit: A non-refundable deposit, which is 25% of your surgery fee, is collected to hold your place on the schedule. The remaining amount will be collected on the day of your surgery. The deposit must be received at the time of scheduling in order to reserve the date and time for you. A 48 hr. notice is required to cancel and reschedule.

Finance Charges: A finance charge of 1.5% will be applied to all accounts over 60 days old. Any amount remaining after insurance has paid is due in full within 14 days.

Attorney & Collection Fees: Fees incurred in an effort to collect will be the responsibility of the delinquent patient.

Returned Checks: In the event your check is returned by the bank a service fee of $30.00 will be applied to your account.

Failure to sign this service contract does not negate the responsible party from financial responsibility with any services rendered as a submission to treatment implies consent as outlined in this agreement. I certify that I have read this Financial Policy and a copy will be available to me upon my request.

Print name of responsible party:_____ Date:_____

Signature of responsible party:_____ Date: _____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a 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 consider confidential.

Who is your Dentist? _____ **Doctor?** _____
Reason for your visit today? _____

Height: _____ Weight: _____

Are you in good health? Y / N

Have there been any changes in your general health in the past year? Y / N

Are you under the care of a physician? Y / N
Date of last visit? _____ If so, what are you being treated for? _____

Have you had any illness, operation or been hospitalized in the last five years? Y / N
If so, describe _____

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? Y / N
If so, describe _____

Do you have a prosthetic joint/implant? Y / N
If so, describe _____

Have you had a heart valve replacement or vascular graft? Y / N
If so, describe _____

Have you had a stroke? Y / N
If so, when _____

Have you ever had general anesthesia? Y / N
If so, describe _____

Have you, or family member, had any usual or serious reactions to general anesthesia? Y / N
If so, describe _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y / N
If so, describe _____

Is there any condition concerning your health that the doctor should be told about? Y / N
If so, describe _____

Do you wish to speak with the doctor alone? Y / N

WOMEN ONLY:

Is there a possibility of pregnancy? Y / N
If yes, when is the expected delivery date? _____
Are you nursing? Y / N
Are you taking birth control pills? Y / N

PLEASE LIST ANY CURRENT MEDICATIONS OR SUPPLEMENTS YOU ARE TAKING:

Medication	Dosage	Frequency

If there is not enough room for all of your medications, please bring a separate paper with the list. Thank you.

Preferred Pharmacy: _____

ARE YOU ALLERGIC OR HAD A REACTION TO:

Local anesthetic (numbing medication) ..... Y / N
Penicillin ..... Y / N
Amoxicillin ..... Y / N
Other antibiotics ..... Y / N
Sulfa Drugs ..... Y / N
Sodium pentothal, Valium, or other Tranquilizers ..... Y / N
Codeine or other narcotics ..... Y / N
Aspirin ..... Y / N
Latex ..... Y / N
Soy ..... Y / N
Eggs/Yolk ..... Y / N
Sulfates ..... Y / N
Do you have any known allergies? ..... Y / N

Please list any other medications or antibiotics you are allergic to:

_____
_____
_____
_____

Please list any other allergies, other than drug allergies

_____
_____
_____
_____

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil, Eliquis, Warfarin)? ..... Y / N
Have you ever taken diet pills? ..... Y / N
Any natural product, herbal supplement or homeopathic remedy? ..... Y / N
Are you taking, or have you ever taken, bone density meds, RANKL inhibitors or bisphosphonates (Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista) in the past 12 years? ..... Y / N
Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics? ..... Y / N
If yes, please list: _____

If you are under the care of a physician for pain management, or recovering from a drug addiction, please select the medication you are currently taking:

- ☐ Methadone
- ☐ Suboxone
- ☐ Oxycodone
- ☐ Fentanyl
- ☐ Other

If other please specify:

_____

HAVE YOU HAD, OR CURRENTLY HAVE:

Blood disorder such anemia? Y / N
Bruise easily? Y / N
Bleeding tendency/abnormal bleed? Y / N
Hepatitis, jaundice, or liver disease? Y / N
Infectious mononucleosis? Y / N
Gallbladder trouble? Y / N
HIV/AIDS? Y / N
Fainting spells? Y / N
Convulsions/epilepsy? Y / N
Thyroid trouble? Y / N
Diabetes? Y / N
Low blood sugar? Y / N
Kidney trouble? Y / N
High cholesterol? Y / N
Are you on dialysis? Y / N
Swollen ankles, arthritis, or joint disease? Y / N
Osteoporosis/osteopenia? Y / N
Osteonecrosis? Y / N
Stomach ulcers/acid reflux? Y / N
Rheumatic fever? Y / N
Damaged heart valves/mitral valve prolapse? Y / N
Heart murmur? Y / N
High blood pressure? Y / N
Low blood pressure? Y / N
Chest pain/angina? Y / N
Heart attack(s)? Y / N
Irregular heart beat? Y / N
Cardiac pacemaker? Y / N
Heart surgery? Y / N
Pneumonia, bronchitis or chronic cough? Y / N

Contagious disease? Y / N
Sexually transmitted disease? Y / N
Problems with the immune system?
Possibly from medication, surgery, etc. Y / N
Delay in healing? Y / N
A tumor or growth? Y / N
Cancer, radiation therapy or chemotherapy? Y / N
What type of cancer? _____
Are you on a diet? Y / N
Contact lenses? Y / N
Eye disease/glaucoma? Y / N
Mental health problems/anxiety/depression? Y / N
Removable dental appliance? Y / N
Pain and clicking of jaws when eating? Y / N
Asthma? Y / N
Hay Fever/Sinus Problems? Y / N
Snoring? Y / N
Sleep Apnea/CPAP? Y / N
Difficult breathing/other lung trouble? Y / N
Tuberculosis? Y / N
Emphysema? Y / N
Do you smoke or vape? Y / N
If so, how much a day? _____
Do you use chewing tobacco? Y / N
Do you use marijuana? Y / N
Do you use any other controlled substance? Y / N
Do you drink alcohol? Y / N
If so, how much a day? _____
Blood transfusion? Y / N
Chronic fatigue / night sweats? Y / N

FAMILY history of:

Cancer Y / N
Heart Disease Y / N
Diabetes Y / N
Anesthesia Problems Y / N
Autism Y / N

I hereby certify that the proceeding information is true and correct. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to me health.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent to insurance carriers and/or healthcare practitioners.

Signature of Patient/Guarantor Date