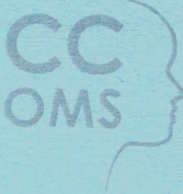

CORPUS CHRISTI
ORAL & MAXILLOFACIAL SURGEONS
Board Certified Oral & Maxillofacial Surgeons

Mance A. Cutbirth DDS MD • Kenneth D. Haynes DDS

Patient Information

Date: ______________

Reason for Today's Visit: ____

Name: ________________________ Social Security#: ______________ Birthdate: __________ Age: _____

Drivers License#: ______________________ State: __________ Exp. Date: __________

Sex: _____ M _____ F Marital Status: ___Single ___Married ___Seperated ___Divorced ___ Widow/Widower

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Home Address: ____________________ City: __________ State: __________ Zip Code: __________

Email Address: ____

Employer: ______________________ Address: ______________________

Emergency Contact: ______________________ Phone: ______________________

Referred By: ______________________ Phone: ______________________

Name of Dentist: ______________________ Phone: ______________________

Name of PCP: ______________________ Phone: ______________________

Have you ever been a patient in this office? ______ Has anyone in your family ever been a patient here? ______

Medical History

	Yes	No
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Defibrillator	☐ Date_____	☐
Pace Maker	☐ Date_____	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Cancer	☐	☐
COPD	☐	☐
Radiation Therapy of Head/Neck	☐ Date_____	☐
Prolonged Bleeding	☐	☐
AIDS or HIV Infection	☐	☐

	Yes	No
Thyroid Disease	☐	☐
Tuberculosis	☐	☐
Epilepsy	☐	☐
Asthma	☐	☐
Major Operation	☐	☐
Blood Disease	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Stroke	☐ Date_____	☐
Hepatitis	☐ Date_____	☐
Allergies	☐	☐

If yes: ______________________________

____

Height_______ Weight_______ Tobacco_______ packs per day Alcohol________ drinks per day

____

____

____

1. Have you been under the care of a physician in the last 2 years? ______________
2. Please list all medications you are taking: ______________________________

____

3. Have you taken any bisphosphonates such as, but not limited to Fosamax or Boniva?

____

4. Are you taking any herbal supplements such as vitamins or diet pills?

____

5. Do you have any medical conditions not listed? (i.e. history of drug/alcohol abuse) ______________

____

6. If female are you pregnant? ☐Yes ☐No

Patient's Name:_________________________________ DOB:_________________ Date:_________________

(Any statements and/or refunds will go to the person listed below)

Name of Person Responsible for Account:____

DOB:____________________ Driver's License#:____________________ SSN/ID#:____________________

Mailing Address of Person Responsible:____

Have you ever served in the military?___ Are you covered under an employer___ Union policy___

Do you Have Dental Insurance? No___ Yes___ if yes, please present both medical and dental cards and fill in all information below.

Primary Dental Insurance:

Name of Insurance:_______________________

Employer:_______________________

Policyholder's Name:_______________________

Policyholders SSN/ID_______________________

Policyholder's Date of Birth:_______________________

Policy or Group #:_______________________

Relationship to Patient:_______________________

Is this plan HMO__PPO__EPO__POS__Other__

Secondary Dental Insurance:

Name of Insurance:_______________________

Employer:_______________________

Policyholder's Name:_______________________

Policyholders SSN/ID_______________________

Policyholder's Date of Birth:_______________________

Policy or Group #:_______________________

Relationship to Patient:_______________________

Is this plan HMO__PPO__EPO__POS__Other__

Primary Medical Insurance:

Name of Insurance:_______________________

Employer:_______________________

Policyholder's Name:_______________________

Policyholders SSN/ID_______________________

Policyholder's Date of Birth:_______________________

Policy or Group #:_______________________

Relationship to Patient:_______________________

Is this plan HMO__PPO__EPO__POS__Other__

Secondary Medical Insurance:

Name of Insurance:_______________________

Employer:_______________________

Policyholder's Name:_______________________

Policyholders SSN/ID_______________________

Policyholder's Date of Birth:_______________________

Policy or Group #:_______________________

Relationship to Patient:_______________________

Is this plan HMO__PPO__EPO__POS__Other__

I, the Undersigned, accept full financial responsibility for the treatment performed by this office. It is the responsibility of the patient, not the dental office, to know what is covered and what is excluded from her or his dental plan, or if a referral is necessary from her or his primary care specialist. Insurance forms will be completed as a convenience to the patient; however; PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED, unless other arrangements are made.

For our records, please check your preference for payment, due at the time of service:

____Cash ____Check ____Visa, Mastercard, Discover, American Express or Care Credit

Signed this __________ day of ________________, 20___. Signature_______________________________

____

Relation to Patient, if Minor

HIPAA AUTHORIZATION FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996** (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT;
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS, (e.g. MY INSURANCE COMPANY)
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF YOUR PRACTICE

I HAVE ALSO BEEN INFORMED OF, AND GIVEN THE RIGHT TO REVIEW AND SECURE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF YOU DO AGREE, YOU ARE THEN BOUND TO COMPLY WITH THIS RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURRED PRIOR TO THE DATE I REVOKE THIS CONSENT IS NOT AFFECTED.

____

SIGNATURE OF PARTICIPANT OR PERSONAL REPRESENTATIVE DATE

____

DESCRIPTION OF PERSONAL REPRESENTATIVES AUTHORITY

____

PRINTED NAME OF PARTICIPANT OR PERSONAL REPRESENTATIVE

CCOMS OFFICE POLICIES

~It is the patient/guardian's responsibility to ask for a school and/or work excuse-excuses will not be emailed/faxed once the patient has left their appointment.

~CCOMS will file ONLY primary dental insurance as a courtesy to the patient. We will gladly give you a receipt once we have received an EOB from your primary insurance so you can file any additional insurances you may have.

~Unless we are in network with your medical insurance, any medical procedures performed in the office or hospital will be collected in full prior to surgery.

~We collect at least a 50% surgical deposit with any regular PPO dental plans prior to surgery on all dental procedures. We will adjust our office fees to the fee schedule of any dental insurance we are in network with. Any overpayment from the patient will result in a refund from our office, and any balance remaining after insurance pays is the responsibility of the patient/guardian.

~I authorize CCOMS to contact me via cell phone, home phone, and/or mail/email regarding my delinquent account(s). I also authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment and/or pre-recorded voice messages and personal phone calls regarding my past due account(s).

~If you do not provide proof of insurance-BOTH medical and dental insurance-i.e insurance cards, computer generated eligibility-we assume you do not have insurance coverage and the surgery will be collected in full-it is the patient/guardians responsibility to provide proof of insurance.

~We only work with the parent that accompanies the patient to their appointment, we do not make payment arrangements over the phone with other parties.

~Any patient being sedated must have a ride that is required to stay in the office during the entire procedure and drive the patient home. If your ride is unable to stay in the office the duration of the surgery, your appointment will be rescheduled.

~Pre-treatment estimates are only sent at the request of our patients, any pre-treatment estimates submitted will only be sent to the primary dental-we do not submit pre-treatment estimates to medical insurances, or secondary dental insurances.

____

Patient/Guardian signature Date