Drs. Bailey, Peoples and Oghalai, P. A.

Account #

Patient Information

First	Middle	Last	Suffix	Preferred Name
Address			City	State/Zip
Home Number ( )	Cell Number ( )	Work Number ( )		Email Address

All telephone numbers provided by you may be subject to receiving telephone calls from an automated dialer using a pre-recorded voice message or live operator call. You give your consent to receive such phone calls, including any calls made to the provided cellular phone number.

Date of Birth	Social Security #	Age	Sex (Circle) M / F	Marital Status (Circle) S / M / D / W
Employer		Employer Address		Status (Circle) FT/PT/Retired/Unemp.
School Information (If Student)		School Address		Status (Circle) FT / PT
General Dentist		Referred By		

PRIMARY DENTAL INSURANCE INFORMATION		SECONDARY DENTAL INSURANCE INFORMATION	
Insurance Name & Address	Company/Employer	Insurance Name & Address	Company/Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insured Name		Insured Name	
Insured Address (☐ Same as above)		Insured Address (☐ Same as above)	
City / State / Zip		City / State / Zip	
Insured DOB	Insured Social Security #	Insured DOB	Insured Social Security #

PRIMARY MEDICAL INSURANCE INFORMATION		SECONDARY MEDICAL INSURANCE INFORMATION	
Insurance Name & Address	Company/Employer	Insurance Name & Address	Company/Employer
Insurance ID #	Insurance Group #	Insurance ID #	Insurance Group #
Insured Name		Insured Name	
Insured Address (☐ Same as above)		Insured Address (☐ Same as above)	
City / State / Zip		City / State / Zip	
Insured DOB	Insured Social Security #	Insured DOB	Insured Social Security #

Guarantor/Responsible Party

☐ SELF (Who is with patient today)

Guarantor Name	Relationship to Patient	Date of Birth	Social Security #
Address (☐ Same as Above)	City/State/Zip		Phone (Home / Cell)

Guarantor/Responsible Party Signature | **Date**

X

Emergency Contact Information

Emergency Contact Name	Relationship to Patient	Phone (Home / Cell)

STAFF INITIAL: _______________

Drs. Bailey, Peoples and Oghalai, P.A.
Health History

Patient ID#:

Patient Name:		**Medical Doctor**	**Phone Number**
Height	**Weight**		

Medications (including Over the Counter / Herbal Supplements) ☐ **See Attached List**

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Have You Had or Do You Currently Have	Y	N	Notes	Have You Had or Do You Currently Have	Y	N	Notes
Abnormal Heart Condition				History of Alcohol Abuse			
Asthma				Joint Replacement (i.e. Hip / Knee)			
Bleeding Condition				Liver Disease			
Cardiac Pacemaker				Osteoperosis Medicine: (Actonel/Risedronate; Didronel;) (Boniva/Ibandronic Acid) (Fosamax/Alendronate) Prolia/Denosumab) (Reclast-Zometa/Zolendronic Acid) (Skelid/Tiludronate Disodium)			
Chemotherapy or IV Drug Treatment: (i.e. Aredia, Bonefos, Zometa) (for cancer: Breast, Prostate, or Multiple Myeloma							
COPD (Emphysema / Chronic Bronchitis)				Radiation (other than x-rays/radiographs)			
Damaged Heart Valves (i.e. Mitral Valve Proplase)				Rheumatic Fever			
Depression				Sleep Apnea			
Diabetes				Smoke / Use Tobacco			
Epilepsy							
Fainting or Black Out Spells				**INFECTIOUS DISEASES**			
Heart Attack / Surgery				Hepatitis			
Heart Murmur				HIV (Aids Virus)			
High Blood Pressure				Tuberculosis			

Allergies

Drug Allergies	Y	N	Notes	Drug Allergies	Y	N	Notes
Clindamycin				Oxycodone			
Codeine				Penicillin			
Erythromycin				Sulfa			
Hydrocodone				Egg, Soy, Peanuts			
Latex				Other			
Local Anesthetic				Other			
				Other			

Women Only

1-Are you currently taking Birth Control? ____ Y ____ N **2-**Are you Currently Pregnant? ___Y ___N (How Far Along? ______)
3-Are you currently nursing? ___Y ___N ****(Please note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician and/or gynecologist for assistance regarding additional methods of birth control.)*****

Additional Comments / Information

By signing below, I acknowledge that I have read and answered the questions above to the best of my knowledge. I will not hold my surgeon or any other member of his staff responsible for errors or omissions that I have made in the completion of this form.

Patient/Guarantor Signature (if under 18)	Date	Staff Initials

Drs. Bailey, Peoples, & Oghalai, P.A.
Privacy Notice & Release of Information

Patient Name: ____

Privacy Notice

I have had the opportunity to review Drs. Bailey, Peoples, and Oghalai, P.A. Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice.

Drs. Bailey, Peoples and Oghalai, P.A. understands that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private. Examples of how we may use or disclose your information is as follows: to obtain payment for our services, in emergency situations, for appointment and patient recall reminders, to avert a serious threat to health or safety, for workers compensation programs, in response to certain requests arising out of lawsuits or other disputes, etc. If you feel your rights have been violated, you may file a written complaint with the practice by contacting our office manager. You will not be penalized for filing a complaint. You also have rights regarding the information we maintain about you. These include the right to inspect and copy, amend, and request restrictions.

Release of Information

( ) I authorize the release of information including: diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

( ) Spouse ____

( ) Children ____

( ) Other ____

( ) Information is not to be released to anyone.

I also understand that I have the right to request restrictions concerning the use of my information. I request the following **RESTRICTIONS**:

( ) Other ______________________ ( ) Other ______________________

The **Release of Information** will remain in effect until terminated by me in writing.

By signing below, I acknowledge that I have read and understand the above information.

Patient Signature (or Guardian if under 18) Date

X______________________ X______________________

If not signed by the patient, please indicate the relationship to the patient.

Relationship ______________________ Staff Witness ____________

INTERNAL USE ONLY

If the patient or patient's representative refuses to sign this acknowledgement of receipt of the NOTICE, please document the date and time the NOTICE was presented to the patient and sign below.

Presented on: __________ (DATE) __________ (TIME) Presented by: ______________________ (Staff)

Revised 09-2014

Drs. Bailey, Peoples and Oghalai, P.A.

Patient Financial Responsibility

The providers and staff at Drs. Bailey, Peoples and Oghalai, P.A. appreciate the confidence you have shown in choosing us for your oral surgical needs. This financial policy is for your benefit in understanding our expectations with regards to payment, insurance and billing.

Payment is due at the time that services are rendered. If other financial arrangements are necessary, they must be made prior to treatment. Any partial paid balances are due and payable within 30 days from the date of services. Interest shall accrue on unpaid balances after the due date at the rate of sixteen percent (16%) per annum, until paid in full.

As a courtesy to you, we will file insurance claims directly with your insurance company, unless your plan requests otherwise. In order to do so, we MUST have accurate information regarding your insurance coverage. Payment of services rendered remains your responsibility, but we will gladly assist you in obtaining reimbursement from your insurance carrier. You are financially responsible for any and all services performed at Drs. Bailey, Peoples and Oghalai, P.A. Please remember that we are non-participating providers with all insurances. An insurance contract is between the patient and the insurance company, NOT the provider. Our office does not accept the responsibility for collecting your insurance claim or negotiating a disputed claim.

You are expected to know and understand your insurance benefits and the insurance reimbursement policies from your carrier prior to your visit. This includes your oral surgical deductibles, co-insurance percentage and/or calendar year maximums as determined by your insurance. Not all services are covered with all insurance carriers. If your insurance carrier does not cover a service or procedure, you are liable for full payment of the bill.

Your estimated down payment is due and expected on the date of service.

You are responsible for providing proof of insurance coverage at each visit to our office and to notify us if your insurance has changed.

Once your insurance company has processed your claim(s), you will be billed or refunded accordingly. Payments are due upon receipt of your statement. Any account over 90 days past due may be turned over to collections.

Increasing delinquency in payment of accounts has made it necessary to obtain written consent to guarantee payment and/or financial responsibility of all accounts. In the event that it is necessary to refer your account to an attorney or collection agency for collection, the undersigned hereby agrees to pay, in addition to the balance due on the account, plus interest as set forth above, all of our costs of collection, including reasonable attorney's fees, collection agency fees, and expense of collection, including but not limited to court filing and service fees.

I hereby authorize Drs. Bailey, Peoples and Oghalai, P.A. to furnish information to my insurance company concerning my care. I further hereby assign all payments for services rendered to Drs. Bailey, and/or Dr. Peoples and/or Dr. Oghalai. I understand that I am financially responsible for all services rendered. I have read the above information and herby acknowledge receipt of a copy of the financial information and agree to the terms stated herein.

______________________________	______________	______________________________
Patient Name (Printed)	Date	Patient/Guarantor Signature

Staff Initials __________