Brady J. Semmel,DMD, MD

PATIENT REGISTRATION FORM

Name: First_____ MI_____ Last_____ Nickname_____

Sex: M/F Race: _____Date of Birth: Month _____ Day _____ Year _____ SSN/ID#:_____

Address: Street _____Apt:_____ City _____State ____ Zip _____

Phone Numbers: Home _____ Mobile _____ Work _____

Email address: _____ **Primary Medical Doctor:** _____

Who referred you to our practice? _____

General Dentist: _____**Other Dental Specialist:** _____

Full time college student? ▫ Yes or ▫ No (CHECK ONE) **If yes, name of school** _____

Insurance Information or Parent/Guardian Information

Name: First_____ MI____ Last_____ SSN: _____

Relationship to patient: (CHECK ONE): ▫ Self ▫ Parent ▫ Guardian ▫ Spouse ▫ Other _____

Address: Street _____ City _____State ____ Zip _____

Phone Number: _____ **Date of Birth:** Month _____ Day _____ Year _____

Employer of Insured Individual: _____ GroupNumber_____

Insurance Company Name: _____Secondary Insurance _____

Do you have **Medicare?** ▫ Yes or ▫ No (CHECK ONE) If yes, please be aware that Dr. Semmel has opted-out of Medicare

Financial Policy: The following financial arrangements are available: (CHECK ONE)

▫ Option A: PAYMENT IS DUE IN FULL AT TIME OF SERVICE

*Cash, personal check, Visa, MasterCard, Discover, American Express or Debit Card accepted.

▫ Option B: DENTAL INSURANCE **Confirm who we are in network with before submitting paperwork**

*Fees for consultation and necessary x-rays are payable in full at the time of service.

*As a courtesy to our patients, the office will file with your insurance company. Patients should understand that all insurance pre-determinations are estimates only. Prior to treatment, your estimated percentage of the total surgery fee is required. (Please be aware that not all insurance companies pay for anesthesia. Should this occur, payment will become your responsibility.) After your insurance has paid/denied, you will receive a final statement showing your remaining balance. The balance will be considered payable in full at the receipt of statement.

▫ Option C: THIRD PARTY FINANCING

*Patients wishing to finance treatment fees may be eligible for commercial financing. Care Credit is offered and can be applied for at www.carecredit.com. We participate in a 6, and 12 month, no interest option. They also offer longer term financing 24, 36, 48, & 60 month periods with reduced APR and fixed monthly payments.

PLEASE BE AWARE: Any balances past 60 days will be charged interest at the rate of 1.5% monthly (18% APR)

Cancellation Policy: Please call the office within 48 hours of appointment if you wish to cancel your appointment. There will be a 75.00 fee if a 48 hour notice isn't provided.

_____ _____ _____

Patient (Guardian) Signature Relationship to patient Date

semmel oral + facial surgery

Brady J. Semmel,DMD, MD

MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

Why are you here today? _____

Were you given any antibiotics or pain medicine? CHECK ONE ▫ YES or ▫ NO

Do you have or have you had the following diseases or problems?
(CHECK all that apply and then explain)

Heart Disease: Heart Attack, Chest Pain, Coronary Artery Disease, Heart Surgery, Pacemaker, Defect at Birth, Valve Replacement, Irregular Heart Beat, Congestive Heart Failure, History of Bacterial Endocarditis, Other

_____

Breathing Problems: Asthma, Bronchitis, COPD, Emphysema, Sleep Apnea, Shortness of Breath, Tuberculosis, Other

_____

Vascular: High Blood Pressure, Low Blood Pressure, Stroke, TIA, Hardening of the Arteries, Other

_____

Endocrine: Diabetes (Insulin Dependent or Non-Insulin Dependent), Hypoglycemia, Thyroid problems, Other

_____

Neurologic: Anxiety, Dementia, Epilepsy, Fainting Spells, Headaches, Seizures, Mentally Handicapped, Other

_____

Liver/Kidney Disease: Hepatitis, Jaundice, Dialysis, Kidney Failure, Kidney Stones, Other

_____

Musculoskeletal: Arthritis, Artificial Joint, Fibromyalgia, MS, Osteoporosis, Other

_____

Gastrointestinal: Ulcers, GERD, Colitis, Crohn's Disease, Gastric Bypass, Other

_____

Head and Neck: Chronic Sinusitis, Swollen Glands, Difficulty Swallowing, Glaucoma, Radiation Therapy, TMJ Disorder

_____

Hematologic: Anemia, Bleeding Disorder, Blood Transfusions, Hemophilia, Leukemia, Lymphoma, Other

_____

Cancer: Breast, Prostate, Lung, Mouth, Colon, Skin, Uterine, Other Cancer, Chemotherapy, Radiation

_____

Immune System: HIV, AIDS, Immunosuppressive Drug Therapy (Remicade, Enbrel, Humira), Other

_____

Females: Pregnant, Breast Feeding, other _____

*Are you to take a "PREMED" antibiotic prior to dental treatment by a medical provider (ex: cardiologist, Orthopedist)? CHECK ONE ▫ YES or ▫ NO

If yes, which antibiotic?_____
For what medical condition?_____

*Have you taken the following Bisphosphonate Drugs? Fosamax, Actonel, Boniva, Reclast, Zometa, Aredia

*Do you use tobacco products? CHECK ONE ▫ YES or ▫ NO
If yes, what products and how often? _____

*Alcohol use: CHECK ONE ▫ None ▫ Social or Occasional ▫ Daily

*Do you have a history of Drug Abuse? CHECK ONE ▫ YES or ▫ NO
Please explain: _____

*Are you currently under a Pain Management Contract? CHECK ONE ▫ YES or ▫ NO
If yes, please list your doctor: _____

*Please list ALL previous SURGERIES you have had with SEDATION (ex: colonoscopy) and dates:
_____
_____
_____

*Did you or any family members have complications following previous surgeries?
CHECK ONE ▫ YES or ▫ NO
Please explain_____

*Did you have Nausea or Vomiting following previous surgeries?
CHECK ONE ▫ YES or ▫ NO

*Are you allergic to any of the following? (Please check all that apply)

▫ Amoxicillin	▫ Eggs	▫ Sulfa Medicines
▫ Anesthetics	▫ Latex	▫ Sulfites
▫ Aspirin	▫ Penicillin	▫ Soy
▫ Codeine	▫ Narcotic	▫ Other _____

*Please list all current MEDICATIONS, HERBAL and/or VITAMINS that you are taking:
_____
_____
_____
_____
_____

Patient (Guardian) Signature:_____ Relationship: _____ Date:_____

Doctor Signature: _____ Date: _____

HIPAA RECEIPT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize *Semmel Oral & Facial Surgery* to disclose personal medical information to the following people: <u>Drivers/Escorts of sedated patients must be listed below</u>

Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

☐ **Yes** ☐ **No** **I authorize *Semmel Oral + Facial Surgery* to leave voice messages.**

If you (*the patient*) are having a procedure under sedation, by signing this form you (*the patient*) will automatically give permission to Semmel Oral & Facial Surgery to disclose personal medical information to your driver/escort on the day of the procedure even if the person is not listed by name on this form.

Patient Name PLEASE PRINT	**Patient (Guardian) Signature**
Relationship to Patient	**Date**