Welcome To Premier Oral and Facial Surgery

1202 Foulk Rd, Wimington DE 19803 & 131 E. Chestnut Hill Rd, Newark DE 19713
www.OralSurgeryDE.com Phone & Fax: 302-273-8300

Welcome!

Welcome to PREMIER ORAL & FACIAL SURGERY! As a new patient at our practice, we kindly ask that you fill out the forms below by following these instructions.

If you are not able to complete the forms before your visit, please arrive 15 minutes earlier to your appointment to allow time to fill out the forms in our office.

Option 1: Fill Out Forms On Your Device & Email

1. Download the forms to your device.
2. Fill out the required fields and save the document.
3. Email the forms to **info@OralSurgeyDE.com**
   or Upload the form in our website
   www. OralSurgeryDE.com/new-patient-registration/

Option 2: Fill Out Forms By Hand & Bring Them To The Office

1. Print the forms.
2. Fill out the forms by hand.
3. Bring them to the office when you come for your appointment.

Option 3: Fill Out Forms On Your Device & Bring Them To The Office

1. Download the forms to your device.
2. Fill out the forms.
3. Save and print the forms.
4. Bring them to the office when you come for your appointment.

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PATIENT INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. **PLEASE PROVIDE A COPY OF YOUR DENTAL & MEDICAL INSURANCE CARD.** All information is kept confidential.

Patient's Name: _____ Today's Date: _____

Sex: (Circle) ○M ○F Age: _____ Birth Date: _____ Soc. Sec: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Spouse's Name: _____

Responsible Party's Name: _____ Birth Date: _____

Soc. Sec: _____ Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician: _____ Referring Dentist: _____

Orthodontist: _____

Reason for Visit: _____

Family members who have been patients here: Member _____

Member _____

Member _____

Member _____

Member _____

HEALTH HISTORY

Patient's Name: _____ Today's Date: _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1) Are you in good health?..... Y N

2) Has there been any change in your general health in the past year?..... Y N

3) Date of last physical exam: _____

4) Are you now under a physician's care for a particular problem?..... Y N

5) Have you ever had any serious illness?..... Y N

6) Height: _____ Weight: _____

7) **DO YOU HAVE OR HAVE YOU EVER HAD:**

A) Rheumatic Fever or Rheumatic Heart Disease?..... Y N
B) Congenital Heart Disease?..... Y N
C) Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?..... Y N
D) Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?..... Y N
E) Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder?..... Y N
F) Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Do you bruise easily?..... Y N
G) Liver Disease (Jaundice, Hepatitis)?..... Y N
H) Kidney Disease?..... Y N
I) Diabetes?..... Y N
J) Thyroid Disease (Goiter)?..... Y N
K) Arthritis?..... Y N
L) Stomach Ulcers or Colitis..... Y N
M) Glaucoma?..... Y N
N) Implants placed anywhere in your body?..... Y N
O) Radiation (X-ray) treatment for Cancer?..... Y N
P) Clicking or popping out of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?..... Y N
Q)Sinus or Nasal problems?..... Y N
R) Any disease, drug, or transplant operation that has depressed your immune system?..... Y N
S)HIV, AIDS, or ARC?..... Y N

8.) **ARE YOU USING ANY OF THE FOLLOWING:**

A) Antibiotics?..... Y N
B) Anticoagulants (Blood Thinners)?..... Y N
C) Aspirinor drugs such as Motrin, Aleve, Ibuprofen?..... Y N
D) High Blood Pressure medications?..... Y N
E) Steroids (Cortisone, etc.)?..... Y N
F) Tranquilizers?..... Y N
G)Insulin or Oral Anti-Diabetic drugs?..... Y N
H)Digitals, Inderal, Nitroglycerin,or other heart drug?..... Y N
I) Any regular prescription medicine, pills, or drugs?..... Y N
if YES, please list them in the next page
J) Herbal or Holistic remedies, Vitamins or over-the-counter medications?..... Y N
if YES, please list them in the next page.
K) Oral or IV Bisphosphonates (Fosomax, Aredia, Zometa, etc.)?..... Y N

9) **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A) Local Anesthesia (Novacain, etc.)?..... Y N
B) Penicilin or other antibiotics?..... Y N
C) Sedatives, Barbiturates?..... Y N
D)Aspirin or Ibuprofen?..... Y N
E)Codeine or other pain killers?..... Y N
F) Latex or Rubber Products?..... Y N
G)Other allergies or reactions?..... Y N

If YES, please list _____

10) Do you smoke or chew Tobacco?..... Y N

11) Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide?..... Y N

12) Have you had any serious problems associated with any previous dental treatment?..... Y N

13) Have you or an immediate family member had any problem associated with intravenous anesthesia?..... Y N

14) Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?..... Y N

15) Do you wish to talk to the doctor privately about anything?..... Y N

16) **FEMALES ONLY:**

A) Are you pregnant, or is there any chance you might be pregnant?..... Y N
B) Are you nursing?..... Y N

C) **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understad the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date: _____ Signature: _____ Doctor's Initials: _____

Medical Update: I have ready my Health History dated: _____ and confirm that it adequately states past and present

Date: _____ Exceptions: _____ Signature: _____ Doctor's Initials: _____

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CURRENT MEDICATIONS

In order for Dr. Dieu to render safe and proper treatment, our office has to be informed of all the medication you are currently taking

Please list, below all the current medications you are taking and this must include all prescriptions, over the counter medication, vitamins and herbal supplements.

Medicine/Supplement	Dosage	Frequency	Medicine/Supplement	Dosage	Frequency

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ALLERGIES & PHARMACY INFORMATION

Date: _____

Patient Name: _____

Are you Allergic to Penicillin? (circle one): **Yes** **No**
Do you expect RX to be delivered? (circle one): **Yes** **No**

Any other Allergies?_____

If patient has list of medications: Can patient take their medications the day of appointment? (circle one): Yes No OR Special instructions:

_____

Pharmacy Name:_____

Full Address:_____ _____ ____ _____
Street City State ZipCode

Pharmacy Phone:_____

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DENTAL AND MEDICAL INSURANCE INFORMATION

Dental Insurance Company: _____

Policy Holders Name: _____ Patient Holder SS#: _____

Policy Holder's Date of Birth: _____ Policy Group #: _____

Policy Holder's Employer: _____

Medical Insurance Company: _____

Policy Holders Name: _____ Patient Holder SS#: _____

Policy Holder's Date of Birth: _____ Policy Group #: _____

Policy Holder's Employer: _____

Patient Name with Medicaid: _____ **Patient Date of Birth:** _____

Medicaid Member ID: _____

Medicaid requires that you disclose any other insurances that cover the patient through the patient's or guardian's work. Please provide other insurances in above section. If you or the guardian fail to disclose these insurances, Medicaid may deny the payments for your services; therefore, you will be fully responsible for all the costs.

Patient signature to acknowledge the Medicaid requirement: _____ **Date:** _____

The following must be signed in order for this office to release information to your dental insurance company regarding your treatment and claim.

I authorize the release of any information to the insurance company relating to my claim

Patient Signature: _____ Date: _____
(or legal guardian if minor)

ASSIGNMENT OF BENEFITS GUARANTEED TO COOPERATE

I authorize, Assign and direct payment of health insurance benefits to the office of Dr. David Dieu, **PREMIER ORAL & FACIAL SURGERY** or monies due on bill which relate to services rendered. I understand that neither pre-authorization nor predetermination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the health insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against health insurance carrier, if there is no timely payment of this claim.

Patient Signature: _____ Date: _____
(or legal guardian if minor)

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NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices's legal duties with respect to my protected healh information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations
- A description of each of the other purposes for which this practice is permited or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My indivudual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to the practice and to the Secretary of HHS if I believe my privacy rights have been violated. and that no retaliatory actions will be used against me in the event of such a complaint
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction
    - The right to receive confidential communications of protected health information
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Signature: _____ Date: _____

(or legal guardian if minor)

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FINANCIAL POLICY

At **PREMIER ORAL & FACIAL SURGERY**, our commitment is to provide you with the highest level of care for years to come. To ensure a clear understanding and avoid any miscommunication, we've outlined our financial policies below.

1. Specialist Care
You are visiting a specialist's office where we manage complex treatments and difficult cases. A clinical examination, consultation, and current x-ray are required by law to be performed by our surgeon before any procedure. This means that examinations done by your primary provider (dentist) do not apply here. If your x-ray is not current or adequate for the planned procedure, a new one will be required. Please note that fees for the examination, consultation, and x-ray may be out-of-pocket expenses if your insurance benefits for these services have been maxed out for the year.

2. Payment
Payment is due in full prior to your time of service. We accept:

- Cash
- Visa, MasterCard, Discover
- Debit Cards
- CareCredit (A Financing Plan)
- Please note that we do not accept personal checks.

3. Insurance Claims
If you have insurance, we will gladly submit claims to most carriers as a courtesy. Payment for deductibles and any estimated out-of-pocket expenses is required prior to your service.

4. Hospital or Surgery Center Charges
If your procedure is performed in a hospital or surgery center, they will bill you separately for their services.

5. Insurance Estimates
We can only estimate what your insurance will cover. The final balance will be determined after we submit your claim and receive the Explanation of Benefits (EOB) from your insurance company. You are responsible for any out-of-pocket expenses at the time of service and any remaining balances after your insurance has paid their portion or made their determination.

6. Balance Payments
Any remaining balance after insurance payment is due within 30 days. If your insurance pays more than the estimated amount, we will refund the excess to you, apply it to any current balance, or keep it on your account for future use. In the event of an over-payment error by your insurance, we will refund them directly.

7. Insurance Information
Please inform our office of any changes to your insurance provider or job status that may affect your coverage or claims.

8. Insurance Requirements
Most insurance companies require the insured's social security number and date of birth. If you choose not to provide this information, we will be unable to file claims on your behalf, and payment in full will be due at the time of service.

9. Signature on File
Your signature on your Financial Policy Form will be used as a "Signature on File" for claims submission. It may also be used for credit applications and debit/credit card payments initiated by you via phone.

10. Financing
Financing options are available through an outside lending source, CareCredit.

11. Outstanding Balances
Outstanding balances are due within 30 days of the statement date. To avoid billing fees and monthly finance charges, please contact our office promptly so we can address any concerns.

12. Missed Appointment Fees

Fees will be charged for missed appointments. A $25 fee applies for a missed consultation, and at least $250 for a missed procedure appointment.

13. Appointment Deposit
A deposit of at least 50% is required to secure your surgical appointment and cover lab fees for long procedures. This deposit will be forfeited if you fail to show up, or if you do not reschedule or cancel at least 2 business days in advance.

14. Collections
If I have an unpaid balance with Premier Oral & Facial Surgery and do not make satisfactory payment arrangements, your account may be placed with an external collection agency. I will be responsible for paying all associated fees (not to exceed 33.3%), reasonable attorney's fees, and court costs. Additionally, a 1.5% interest charge per month will be applied to any remaining balance after 30 days.

15. Contact Authorization
To service my account, I authorize Premier Oral & Facial Surgery and their designated external collection agency to contact me via telephone, including wireless numbers (which could result in charges), text messages (message and data rates may apply), and emails using any email address I provide. Contact methods may include pre-recorded/artificial voice messages and/or an automatic dialing device where applicable.

Patient or Guardian's Signature: _____

Today's Date: _____