Greater Houston Oral and Facial Surgery, P.A.
Patient Registration and Medical History

Referred By_____ General Dentist_____
Patient Full Name_____ Sex M/F D.O.B_____/_____/_____ Age_____
Weight_____ Height_____ SS#_____-_____-_____ Home # (_____)_____-_____
Home Address_____ Apt#_____ City_____ State____ Zip_____
Patient's or Parent's Employer_____ Work # (_____)_____-_____ Ext____
Business Address_____ Cell Phone #(____)_____-_____
Marital Status (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Spouse or Parent's Name_____ Employer_____ Phone #(_____)_____-_____
If Patient is a Student, Name Of School/College_____ City_____ State_____
Name of Person Responsible for this Account _____ Relationship to patient_____
Driver's License#_____ and State_____

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____
Insured's SS#____-____-____ Name of Insured's Employer_____ Insured's D.O.B___/___/____
Dental Insurance Company _____ Phone #(____)_____-_____ Group #_____
Medical Insurance Company_____ Phone #(____)_____-_____ Group #_____

HEALTH HISTORY INFORMATION

Reason of your visit today? _____
Approximate date of last dental visit_____
When were you last examined by a physician? _____
Physician's name and phone number_____
Are you allergic to any dental anesthetics? _____
Are you allergic to any medications? _____
List of medications taking now_____
Do you take Aspirin daily?_____
Do you smoke? YES / NO If yes, how much per day?_____ Do you drink alcohol? YES / NO if yes how often? _____
Name of person to contact in case of an emergency_____ Phone # (____)____-_____
Relationship_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK BOXES THAT APPLY)

☐ High Blood Pressure	☐ Rheumatic Fever	☐ Mitral Valve Prolapse	☐ Epilepsy	☐ Hyperthermia
☐ Bleeding Problems	☐ Steroid Last 2 Year	☐ Nervous-Depression	☐ Hepatitis	☐ Low Blood Sugar
☐ Diabetes	☐ Tuberculosis	☐ Emphysema	☐ Pregnant-Now	
☐ Osteoporosis Meds	☐ Heart Valve Disease	☐ Chemotherapy Radiation	☐ Lupus	
☐ Low blood pressure	☐ Heart Problems	☐ Heart Surgery	☐ Sinus Problems	
☐ Cancer	☐ Asthma	☐ Neurological disorder	☐ Gastrointestinal Problems	
☐ A.I.D.S/ H.I.V positive	☐ Bronchitis	☐ Joint Implants	☐ Mental Retardation	
☐ Pacemaker	☐ Blood thinners	☐ Arthritis	☐ Heart Murmurs	
☐ Respiratory Problems	☐ Kidney Problems	☐ Dialysis	☐ Blood Disorders	
☐ Liver Disease	☐ Thyroid Disorders	☐ Severe Headaches	☐ Epilepsy-Seizures	
☐ Skin Disorders	☐ Heart Attack	☐ Stroke	☐ Immune Disorders	

List any other medical problems you have or have had that are not covered in this questionnaire. If none please write none._____
I have answered all of the above to the best of my ability. I understand that I am responsible for any unpaid fees not covered by my insurance. I understand that there will be a fee of $15.00 if my account is sent to a collection agency. A $25.00 fee will be charge for a check returned to the office for any reason.

Patient Signature_____ Date____/_____/_____

Greater Houston Oral and Facial Surgery, PA

Financial & Insurance Guidelines

We are committed to providing you with the best possible care while working hard to control cost and keep our fees as low as possible. While trying to control our cost, we are also striving to make sure our facilities and staff are the best available to meet your surgical needs. If you have dental or medical insurance, we are anxious to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment guidelines.

Un-insured patients- For those patients without insurance, we ask that payment be made at time of service. Payment may be made using a credit card, cash or check. If you cannot provide the entire payment at time of service please contact our office directly so that we can work with you to see if other arrangements can be made.

Insured patients- We will gladly discuss your proposed treatment and answer general questions regarding insurance. Your insurance is a contract between you and your insurance carrier; we are not involved in that relationship. Our fees generally fall within what insurance companies call "reasonable and customary". This does not apply to companies that choose to allow a certain amount arbitrarily decided by them. **Not all services are covered benefit under all insurance contracts.** We must emphasize that as surgical care providers, our relationship is with you, not your insurance company. While the filing of your insurance claim is done for you as a courtesy by our office, the charges incurred are your responsibility from the date of service. We strongly recommend that you help us follow-up with your insurance carrier to make sure all their questions are answered and that they are processing the claim in a timely manner. We would be more than happy to send a prior authorization to your carrier to determine your exact benefits.

We will file your insurance claim the day of your visit and will try to ensure that your insurance carrier has all the information needed when the claim in filed. However it is also up to you to follow-up and make sure that they are timely in their processing of your claim. At 30 days, we will follow-up with your insurance carrier and again at 45 days to determine status of claim and to answer any questions. At these times, you will also be advice of your account's status. If at 60 days the insurance company has not paid, arrangement for you payment on the account must be made- you should contact your insurance company immediately regarding the non-payment of your payment.

All patients- We are always willing to work with you as long as reasonable efforts are made to pay for our services. At 90 days, if the account is not paid, we must begin a more aggressive process for collecting our fees. You will be advised that collection proceedings will begin at 90 days. We regret when this action is necessary, but we feel we have made significant effort to help our patients find a way to provide payment. All balances are due at 90 days. Any account with balances 90 days past due will accrue a finance charge of 1.5% regardless of pending insurance payments. All charges incurred in the recovery of a delinquent account will be the patient's responsibility.

We hope you find these guidelines within reason and are comfortable with our terms and conditions for payment. Please understand that any deposit request of you is only an estimate of your responsibility. The amount may vary depending on your particular co-payment, which may include payment for some charges incurred which are not covered by your insurance carrier. You are ultimately responsible for the balance of your account for any services rendered. Please sign below signifying that you have to read and understand our guidelines. We thank you for giving us the opportunity to serve your surgical needs.

Signature:_____

Printed patient's name:_____

Date:_____

Greater Houston Oral and Facial Surgery, P.A.

PATIENT QUESTIONAIRE AND HIPPA ACKNOWLEDGEMENT

TEXAS MEDICAL RECORDS AND PRIVACY POLICY:

I hereby give my consent for the doctors at Greater Houston Oral and Facial Surgery, P.A. to use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations. I give consent for this practice to contact me in the following manner:

PLEASE CIRCLE EITHER YES OR NO AND SIGN BELOW:

May we send you a post card to inform you that it is time for your re-call appointment to your mailing address if indicated? **Yes** **No**

Leave a message on your answering machine at home? **Yes** **No**

Leave a message on your cell phone? **Yes** **No**

Leave a message at your place of employment? **Yes** **No**

Leave a message on your email? **Yes** **No**

Discuss your condition/results with a family member? **Yes** **No**

If yes, who?_____Relationship_____Phone_____
Comment:
_____

I understand that I may revoke any and all permissions listed about by sending request in writing to 4007 Woodlawn Pasadena, Texas 77504, or by calling 713-944-0864. Once the request is received, I understand that the correction will be made and removed from the list or modified within the 45 days as required by Texas law.

The office of Greater Houston Oral and Facial Surgery, P.A .has provided me a copy of my rights upon my request and these rights are posted in the waiting room of the office, as stated under the HIPPA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have any questions, please address them with the office staff during your visit.

_____ _____

Patient or legal guardian **Date**

Greater Houston Oral and Facial Surgery, P.A.

Acknowledgement of Receipt

Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. By signing below I consent the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice. I also understand that I have the right to not sign this agreement.

Name_____
Signature_____
Relationship to patient_____
Date_____

If we are unable to get your acknowledgement then our office will make notation as to the reason why it is not obtained.

Reason why acknowledgement was not obtained:

_____
_____
_____

Staff Name: _____
Signature:_____
Date:_____