Welcome to Maine Oral Surgery and Dental Implant Center

Erik J. Harriman, DMD, MD

PATIENT INFORMATION

First Name_____ M.I.____ Last Name _____ BirthSex: ❑ M ❑ F

Birth Date_____ Age_____ Soc. Sec. #_____

Street _____ City _____ State _____ Zip _____

Phone#1 (_____) _____ Phone#2 (_____) _____ Email: _____

Employer _____ Referring office _____

Dentist _____Orthodontist _____

Medical Doctor _____ Medical Specialist _____ Pharmacy _____

IF PATIENT IS A MINOR, accompanying parent/guardian information: ❑Father ❑ Mother ❑ Other (relation) _____

First Name _____ Last Name _____ S.S.# _____ Birth Date_____

Cell (_____) _____ Home (_____) _____ Work (_____) _____

Street _____ City _____ State _____ Zip _____

*I AUTHORIZE THE RELEASE OF MY MEDICAL AND FINANCIAL RECORDS TO THE FOLLOWING:

Name _____ Relationship _____ Phone# _____

PRIMARY INSURANCE

DENTAL MEDICAL

Insurance co. name:		Insurance co. name:	
Subscriber name & relation:	Subs. DOB	Subscriber name & relation:	Subs. DOB
ID.	Group #	ID.	Group #

SECONDARY INSURANCE

DENTAL MEDICAL

Insurance co. name:		Insurance co. name:	
Subscriber name & relation:	Subs. DOB	Subscriber name & relation:	Subs. DOB
ID.	Group #	ID.	Group #

HIPAA ACKNOWLEDGEMENT I acknowledge receipt of a copy of Maine Oral Surgery's Notice of Privacy Practices or that I have been made aware that one is available in the event that I would like to request a copy.

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR) PRINT NAME DATE

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Chronic headaches
- ❑ Circulatory problems
- ❑ Damaged Heart Valves
- ❑ Diabetes
- ❑ Emphysema
- ❑ Endocrine Abnormalities
- ❑ Excess weight loss/gain
- ❑ Fainting tendency
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ Heart trouble/attack/surgery
- ❑ Hepatitis/liver trouble
- ❑ High/low blood pressure
- ❑ Infectious disease
- ❑ Jaundice
- ❑ Kidney problems
- ❑ Lung problems
- ❑ Malignancy(tumor)
- ❑ Osteoporosis/Osteopenia
- ❑ Pacemaker
- ❑ Porphyria
- ❑ Psychiatric treatment
- ❑ Radiation therapy
- ❑ Rheumatic fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Seizures/Epilepsy
- ❑ Sleep Apnea
- ❑ Stroke/TIA
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal disease

Other illnesses or diseases: _____ _____ _____ _____ _____

Surgical history: _____ _____ _____ _____ _____

Please list any medications you are currently taking: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Please list any allergies that you have: _____ _____ _____ _____

Are you **allergic** to any medication, local anesthetic, drug or food?	**Y**	**N**
Is your general health good?	**Y**	**N**
Have you seen or been under the care of a physician during the ***past two years***, other than for *routine care*?	**Y**	**N**
Have you had any disease, illnesses, operations, hospitalizations ***within the past five years***?	**Y**	**N**
Are you taking any **medications** currently?	**Y**	**N**
Are you presently taking **steroids, blood thinners or insulin**?	**Y**	**N**
Are you taking or have you ever taken a BISPHOSPHONATE or ANTIRESORPTIVE medication? Prolia, Fosamax, Actonel, or Boniva for osteoporosis Xgiva, Aredia, Reclast or Zometa to prevent cancer spread?	**Y**	**N**
Have you ever had any excessive or abnormal bleeding?	**Y**	**N**
Have you or a family member ever had a complication from a general anesthetic?	**Y**	**N**
Have you ever had a complication from a local anesthetic?	**Y**	**N**
Women: Are you pregnant? If yes, how many months? _____ Are you nursing? _____	**Y**	**N**
Do you smoke? ❑ Tobacco ❑ Nicotine If yes, how much? _____	**Y**	**N**

❑ Marijuana		
Do you or have you ever taken narcotics?	**Y**	**N**
Do you drink alcohol daily?	**Y**	**N**
Do you wear dentures or contact lenses?	**Y**	**N**
Do you have any artificial joints or implanted devices? If yes, what kind: _____	**Y**	**N**
Is there anything else we should know about your medical history? _____	**Y**	**N**

The above health questionnaire is true to the best of my knowledge. Further, I authorize insurance payment directly to the Oral and Facial Surgery Center and agree to be responsible for all costs of treatment to which I consent.

SIGNATURE OF PATIENT(PARENT/GUARDIAN IF MINOR) PRINT NAME
DATE

Maine Oral Surgery and Dental Implant Center

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FINANCIAL POLICY

- All services rendered are subject to review until paid by insurance and therefore the amount we collect for your co-pay is only an **ESTIMATE**. Once the claims are paid adjustments will be made.
- If requested, we can submit a predetermination of benefits to your insurance; this can delay surgery for 4-8 weeks and is still not a guarantee of payment.
- If you have out of network insurance then you will need to pay for all services and we can file to your insurance for reimbursement.
- The patient, or legal guardian for minors, is responsible for all amounts not covered by the insurance.
- If after 90 days there is still a balance on the account, the patient or legal guardian is responsible for the balance, all rebilling charges, interest charges, collection costs and attorney fees.
- **Full payment is due at time of service**.
- If you do not provide at **least 24 hours notice when canceling** or rescheduling a surgery appointment, you must pre-pay your co-pay prior to making another appointment and/or you will not be rescheduled.
- **THE INDIVIDUAL PAYING FOR THE SERVICES RENDERED MUST BE PRESENT IN OUR OFFICE AT THE TIME OF PAYMENT.**

- Patient payments can be made by cash, credit card or Care Credit.

- **If your copay exceeds $1,000.00 it must be pre-paid three days prior to your appointment.**

I have read, understand and agree to this financial policy.

_____

_____

Signature of Patient / Responsible Party **Date**

_____

_____

Name of Patient **Name of Responsible Party (if patient is a minor)**