CHERRY TREE

ORAL AND MAXILLOFACIAL SURGERY

JAY E. COWAN, D.D.S.

PATIENT NAME_____ **DATE** _____

ADDRESS_____ **CITY**_____ **ST**_____ **ZIP**_____

HOME PHONE_____ **CELL**_____ **WORK**_____

BIRTHDATE_____ **AGE**____ **SEX: M**☐ **F**☐ **STUDENT: PT**☐ **FT**☐

SSN (*Required if you are 18 or older*) _____ **MARITAL STATUS**_____

EMPLOYER/SCHOOL name & address_____

DENTIST_____ **PHYSICIAN**_____ **ORTHODONTIST**_____

EMERGENCY CONTACT_____ **PHONE**_____

PRIMARY INSURANCE INFORMATION **(Person carrying insurance on this patient)**

NAME_____ **BIRTHDATE**_____ **RELATIONSHIP**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

INSURANCE CO_____ **ID#**_____ **MEDICAL**☐ **DENTAL**☐

PHONE_____ **ADDRESS**_____

SSN #_____

GROUP ID AND EMPLOYER _____

SECONDARY INSURANCE INFORMATION

NAME_____ **BIRTHDATE**_____ **RELATIONSHIP**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

INSURANCE CO_____ **ID#**_____ **MEDICAL**☐ **DENTAL**☐

PHONE_____ **ADDRESS**_____

SSN # _____

GROUP ID AND EMPLOYER _____ ***(OVER)***

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MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

___ALLERGIES (SEASONAL)
___ANEMIA
___ANGINA PECTORIS
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINT (HIP,KNEE)
___ASTHMA
___BLEEDING ABNORMALLY
___CANCER
___RADIATION
___CHEMOTHERAPY
___CHEMICAL DEPENDENCY
___CONGENITAL HEART LESION
___CORTISONE MEDICINE
___DEPRESSION
___DIABETES (insulin Y☐ N☐)
___EMPHYSEMA
___EPILEPSY OR SEIZURES
___GLAUCOMA
___HEART FAILURE
___HEART DISEASE OR ATTACK
___HEART MURMUR
___HEART PACEMAKER
___HEART SURGERY
___HEMOPHILIA
___HEPATITIS A
___HEPATITIS B
___HEPATITIS C
___HIGH BLOOD PRESSURE
___HIV POSITIVE
___KIDNEY DISEASE
___LIVER DISEASE
___MITRAL VALVE PROLAPSE
___PAIN IN JAW JOINTS
___SICKLE CELL ANEMIA
___STROKE
___SWOLLEN NECK GLANDS
___THYROID PROBLEMS
___TOBACCO or ALCOHOL USE
___OSTEOPOROSIS
___SLEEP APNEA

Women Only:

Are you pregnant or anticipating becoming pregnant? Y☐ N☐
Due date _____

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER MEDICATIONS:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

LIST ANY OTHER SERIOUS DISEASE OR ILLNESS:_____

LIST PREVIOUS PROBLEMS WITH EXTRACTIONS OR SURGERIES:_____

HAVE YOU BEEN HOSPITALIZED WITHIN THE LAST FIVE YEARS?_____

ALLERGIES

___ASPIRIN ___ACHROMYCIN ___CODEINE ___MORPHINE ___IODINE ___PENICILLIN ___LATEX ___SULFA

___TETRACYCLINE OTHER:_____

I understand the above information is necessary to provide me with oral surgery care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I will not hold Dr. Cowan or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

The undersigned hereby authorizes Dr. Cowan to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Cowan to make a thorough diagnosis of the patient's oral surgery needs.

X_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Cowan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

REV:01/17

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JAY E. COWAN, D.D.S.

Thank you for choosing my practice for your oral surgery needs. I am committed to providing you with the best overall possible care. This includes proper and timely handling and filing of your insurance claims. However, you must realize your insurance is a contract between you, your employer and the insurance company. It is your responsibility to furnish complete insurance information at the time of your appointment. Without the complete insurance information we will be unable to properly file your claim and therefore, you will be responsible for the entire bill at the time of your appointment. Our office will do everything possible to assist you and your insurance company in processing your claim.

Insurance companies pay a percentage of the "Usual and Customary" charges. These fees do not always match the doctor's fees; therefore, we will provide you with an estimate of what the insurance will cover and what your surgery deposit will be. This deposit will be due the day of surgery. The surgery deposit is only an ESTIMATE. If your insurance pays more than quoted to you, we automatically refund to you any overpayment. If the insurance pays less, you will be billed for the remaining balance. Account balances which are 90 days or over from the date of service, payment will be expected in full by the person who signed financial responsibility for the account. If you have any questions regarding this policy, please feel free to speak with us.

In consideration of the services provided to the patient, I/we hereby guarantee payment in full of the patient's account within thirty (30) days from payment of insurance. I/we agree that in the event of default in payment, reasonable collection agency fees equal to thirty (30%) percent of the delinquent balance, and/or reasonable attorney fees shall be added to the amount due on the account, plus any applicable court costs.

CANCELLATION POLICY: To avoid a $30.00 charge, a 24-hour notice is required for cancellation of your scheduled appointment.

Patient _____

I understand the above and am aware that I am responsible for this entire account, not my insurance company, although the insurance may pay a portion of the fee charged.

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

_____

Signature (financially responsible) **Print name** **Relationship to patient**

Home Address_____ **Date**_____
Employer_____ **WK#**_____
Work Address_____
Guarantor Social Security # ___-___-_____ (REQUIRED INFORMATION) and provide a copy
Date of Birth____/____/_____ of your driver's license--DL#_____- ___-_____

Guarantor's Phone

(___)____-_____ (___)____-_____ (___)____-_____
HOME **Work** **Cell** **By providing my cell number, I give prior express consent to receive calls and text messages from the creditor or its third party debt collector at that number, including calls and messages made by using an auto-dialer or prerecorded message.**

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CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

Our office honors the HIPAA Privacy Act.

I _____, Date of Birth: _____, requests the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include my name, diagnosis(es), test results, dates of service, procedures performed, and pre-op and post-op information.

PLEASE CHECK ALL THAT APPLY

___ You may disclose information to my family members and/or non-family members listed below:

Name:_____, Phone #_____Relationship _____
Name:_____, Phone #_____Relationship _____
Name:_____, Phone #_____Relationship _____

___ You may leave Protected Health Information on my answering machine/voicemail/cell.
Phone #: _____ Cell #: _____

My signature below is acknowledgement of receipt of "NOTICE OF PRIVATE PRACTICES"; and I have been offered a copy of the office's Privacy Practices.

_____ Date _____
Patient's Signature (or if minor signature of guardian)

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