Peoria Oral & Implant Surgery

PATIENT REGISTRATION FORM

First Name _____

Last Name _____ M.I._____

Address_____

_____

City _____

State _____ Zip _____

Date of Birth _____

Referring Doctor _____

Social Security# _____

Driver's License# _____ State _____

Home Phone _____

Cell Phone* _____

Work Phone _____

Email* _____

Employer _____

Billing Address (if different from above):

_____

City _____ State _____ Zip _____

Account Responsible Party-

FirstName _____

Last _____

Address _____

City_____ State _____ Zip _____

Cell _____ Home #_____

Email* _____

Social Security# _____

Driver's License# _____State ____

Cell Phone* _____

Employer _____

Pharmacy Name:_____ Phone#_____

Address or Cross Streets:_____

Please fill in the information for the name of the person who holds the insurance policy.

Dental Insurance

Insurance Company Name _____

Subscriber's Name-

First _____

Last _____

Subscribers Birth Date _____

Employer _____

Medical Insurance- Please hand medical insurance card to front desk- this is necessary to process dental insurance claims.

Insurance Company Name _____

Subscriber's Name-

First _____

Last _____

Subscribers Birth Date _____

Employer _____

Cancellation Policy

Peoria Oral & Implant Surgery requires the following for all patients scheduled for surgery

-You will be charged $100.00 if notice for cancellation is not given 48 hours in advance.

-Please arrive 15 minutes prior to your scheduled surgery time.

-This policy is in place to provide other patients with the same courtesy as we have provided you.

Request for Records

A copy of any of your records may be obtained for a fee of $40.00.

Patient (Legal Guardian) Signature _____

Date:_____

Practice Policies- Please Read and Initial

_____Please be ready to provide us with a copy of your insurance card and photo I.D. If you obtain new insurance or have additional dental insurance you want us to consider, it must be preapproved at least 7 days prior to scheduled appointments. It is patient responsibility to keep insurance updated and current.

_____We do require both a cell phone and email address on file, as our office is fully digital. This helps us to process your insurance in a most timely manner.

_____Patient Co-Pays are due prior to treatment.

_____Appointments requiring anesthesia must be reserved with a $100 deposit. The deposit can be used towards your patient copay. Our cancellation policy: Deposits are nonrefundable if cancelled without 48 hours' notice.

_____We utilize a 3rd party billing system for processing dental insurance. Insurance takes at minimum 30-60 days to process, not including the time for our claims department to make updates to your patient account. If refund is due, we issue these the last week of each month, no exceptions will be made and are issued by check.

Non-Covered and Non-Chargeable Benefits

This is a notice to the patient that there are procedure codes that insurance won't cover. We do submit with narratives on the patient's behalf, but with some procedures there is a high probability that the insurance company will say it is a non-covered benefit, or furthermore they will say it is a bundled procedure and therefore the doctor cannot charge for it. We try to be diligent and notify our patients ahead of time if a procedure isn't covered. This is a notice that all procedures are billed independently and the treating physician reserves the right to collect a fee for each procedure performed, regardless of what insurance dictates.

Print Name: _____

Signature: _____

Date: _____

MEDICAL HISTORY FORM

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

For the following questions, circle yes or no. Your answers are confidential.

1. Are you generally in good health Yes No
2. Has there been any changes in your health in the past year Yes No
3. My last physical exam was on_____/_____/_____
4. Are you now under the care of a physician? Yes No
5. The name and address of my physician is:_____
   _____
   _____
6. Have you ever had a serious illness, significant operation or hospitalization? Yes No
   If so, please explain:_____
7. Are you taking any medicines including non-prescription, homeopathic or "natural" Yes No
   Please list:_____
   _____

8. Do you have or have you had any of the diseases or problems below?
   a. Damaged heart valve, artificial valve or heart murmur Yes No
   b. Rheumatic Fever Yes No
   c. Cardiovascular Disease (Heart Attack, Angina, Coronary Artery Disease) Yes No
   d. Arrythmia (Pacemaker, Atrial Fibrillation) Yes No
   e. Chest pain on exertion, Shortness of Breath, Swollen Ankles Yes No
   f. Congenital Heart Disease Yes No
   g. Stroke Yes No
   h. Hypertension (High blood pressure) Yes No
   i. Diabetes Yes No
   j. Hepatitis A/B/C, Jaundice or Liver disease Yes No
   k. Stomach ulcer or Gastric reflux Yes No
   l. Kidney problems Yes No
   m. Asthma, Chronic Bronchitis or Emphysema Yes No
   n. Allergies, Sinus trouble Yes No
   o. Arthritis, Replaced joints (Prosthetic Joint) Yes No
   p. Anxiety, OCD, Panic Attacks, PTSD Yes No
   q. Depression, Bipolar, Schizophrenia Yes No
   p. ADD, ADHD Yes No
   r. Neurologic disorder, Epilepsy, Seizures Yes No
   s. Tuberculosis, Persistent cough that produces blood Yes No
   t. Cancer (Chemotherapy, Radiation treatment) Yes No
   u. Organ Transplant Yes No
   v. HIV/AIDS Yes No
   w. Immune disorder, Chronic Fatigue syndrome, Long COVID syndrome Yes No
   x. Bleeding disorder (Hemophilia, Von Willebrand, Sickle cell) Yes No
   y. Blood transfusion, Anemia Yes No
   z. Thyroid problems Yes No

9. Do have a condition or medical problem that you think the doctor should know about?
If yes, please explain:_____
_____

10. Are you allergic to any medications or latex? Yes No
Please list:_____
11. Do you smoke cigarettes or chew tobacco? Yes No
How many years?_____ How many packs per day?_____
12. Do you drink alcohol? Yes No
13. Do you or have you used (Non Prescription or IV drugs)? Yes No
14. Do you wish to talk to the Doctor privately about anything? Yes No

Women Only

15. Are you pregnant or any chance you might be pregnant? Yes No
16. Do you have problems associated with your menstrual period? Yes No
17. Are you nursing? Yes No
18. Are you taking birth control pills? Yes No

Oral Health

19. Do you see a dentist regularly? Yes No
20. Have you had any serious problems associated with previous dental treatment? Yes No
21. Do you have any lesions or growths in your mouth that concern you? Yes No
If so, please explain:_____

Chief Complaint_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered truthfully and to my satisfaction. I will not hold my oral surgeon or any members of the staff responsible for any errors or omissions that I may have made in completion of this form.

Date:_____Patient's (Guardian) Signature_____

FOR COMPLETION BY THE DOCTOR/STAFF

Vitals:
Heart Rate_____ Blood Pressure_____ Heart Rate_____ Blood Pressure_____

Comments On Patient Medical History:_____
_____
_____
_____
_____

Date:_____Doctor's signature_____

Medical History Update:

Date	Comment	Patient Signature	Dr. Signature
_____	_____	_____	_____

FINANCIAL POLICY

INSURANCE {PLEASE NOTE- PATIENT PORTION IS DUE AT THE TIME OF SERVICE}

-This form allows assignment of your benefits to Dr. Nino Pollaccia and/or Peoria Oral & Implant Surgery.

-As a courtesy to you, we will bill your insurance company and track all claims, however, an estimated portion of your treatment cost will be collected prior to surgery. Both Federal Laws and contracts with your insurance company prohibit us from waiving those fees. To expedite your claim please provide us with your most current insurance coverage and keep us informed of any changes to your insurance plan.

Ultimately, you are responsible for all fees charged by our office, regardless of insurance coverage.

-If the doctor does not have a direct contract with your insurance company, you will be responsible for the treatment amount at the time of service. We will provide you an itemized statement to file directly with your insurance company for reimbursement. Please note any amount reimbursed to us on filed claim above our UCR will be retained as out of network provider and your paid amount will be reimbursed.

-I understand that my insurance may not cover the initial exam, consultation, panoramic radiograph or 3D CT radiograph charges, but a claim will be sent to my insurance company. I also understand that although I have insurance, certain Oral Surgery procedures are not covered by my insurance, and I am responsible for Peoria Oral & Implant Surgery's UCR fee for those procedures.

NO INSURANCE

This is considered a CASH patient. Payment is due in full at time of service. Payments may be made by Cash, Debit Card, Money Order, Check, Credit Card (Visa, Mastercard, Discover, American Express) or Care Credit. Apply in our office or online www.carecredit.com our staff will be happy to assist you in the application process and choosing the payment option that works best for you.

FEES

There are no additional fees from our office when using care credit. For major credit card use you will be charged a one-time 3% processing fee. The time and cost to issue a reimbursement is $10.00, any credit balances $10.00 or less will have a debit issued and your account will be adjusted to zero balance.

PAYMENT TERMS

Most insurance companies will have responded to a claim within 4-6 weeks of claim submission. At that time, we will send you a statement of your balance so that you will know what your insurance company has covered, and any remaining balance owed. If payment from the insurance company has not been received in 60 days, payment in full is due directly to us. All accounts that are 60 days past due are considered delinquent and may be sent to collections and listed with the Credit Bureau. In the event of default, the undersigned agrees to pay the outstanding balance, interest charges and all collection and attorney fees applicable to the collection thereof. The only type of payment that will be accepted to clear the account is cash, debit card or money order.

By my signature, I certify I understand the above and agree to abide by the conditions stated.

Print Patient or Responsible Party Name:_____

Signature Patient or Responsible Party Name:_____

Date:_____

AUTHORIZATION RELEASE FORM FOR MEDICAL/DENTAL RECORDS

By signing this document, I (Patient or Legal Guardian) authorize any doctor, administrator, agent, or other employee of Peoria Oral & Implant Surgery to obtain and/or release the following medical/dental information: medical/dental history, x-rays, medical insurance, dental insurance, treatment plan, billing, accounting disclosures or any other information related to my medical/dental record. I also otherwise any doctor, administrator, agent, or other employees of Peoria Oral & Implant Surgery to speak with any individual regarding my medical/dental information.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions, per your request, and no longer protected by these regulations.

Please release these records to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

Please send my records to:

Dr. Nino Pollaccia and Staff

Peoria Oral & Implant Surgery

10210 W. Happy Valley Rd. Suite #150

Peoria, AZ 85383

P: 623-230-2297

F: 623-239-3547

Email: info@peoriaoralsurgery.com

Print Patient (Legal Guardian) Name/Relationship:_____

Patient (Legal Guardian) Signature: _____

Date:_____

HIPPA ACKNOWLEDGEMENT FORM

This form acknowledges your receipt of Notice of Privacy Practices

I, _____ understand that as part of my healthcare, this facility originates and maintains health records describing my health history including but not limited to: symptoms, examination, radiographs, photos, test results, diagnosis, treatment, cost of treatment, insurance information, and any plans for future care or treatment. I acknowledge that I have been provided with and understand Peoria Oral & Implant Surgery's Notice of Privacy Practices which provides a complete description of the uses and disclosures of my health information. I further understand that:

I have the right to refuse to sign this form.

I have had the right to review this facilities Notice of Privacy Practices prior to signing this form.

This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of changes a copy will be e-mailed to me if requested.

Print (Legal Guardian) and/or Patient Name:_____
Signature(Legal Guardian) Patient:_____
Date:_____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited signing

___ Emergency situation occurred prohibiting signing

___ Other Specify _____
_____.