Welcome

The Institute of Oral & Maxillofacial Surgery, LLC

Date_____ Social Security Number_____

Name_____ Email_____

Address_____Apt/Bldg#_____

City_____State_____Zip_____

Sex M F Birthdate_____ Marital Status S M W D

Phone (___)_____Parent/Spouse # (___)_____Alternate #(___)_____

Patient Employer/School Information

Patient Employer/School _____Phone (__)_____

Employer/School Address _____

Whom may we thank for referring you?_____

Parent/Guardian Information: (Skip if this does not apply to you)

With whom does this patient reside: (Circle all that apply)

Mother Father Step-mother Step-father Grandparents Other_____

Parent/Guardian Name _____Relationship_____

Phone (___)_____ Work (___)_____ DOB _____

Emergency Contact (someone not living with you)_____

Relationship _____ Phone (___)_____

Health History

Name_____Date Of Birth_____Date_____

Height_____ Weight_____

Are you in good health? Y N
Has there been any change in your
General health in the last year? Y N
Date of last physical exam_____
Are you under the care of a physician For a particular problem? Y N
Have you ever had a serious illnesses Operations, or hospitalizations? Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

Rheumatic Fever? Y N
Rheumatic Heart Disease? Y N
Congenital Heart Disease? Y N
Cardiovascular Disease (Heart Attack, Heart Murmur, Heart Trouble, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N
Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, TB. Shortness of breath, Chest pain, Severe Coughing?) Y N
Seizures, Convulsion, Epilepsy, Fainting or Dizziness? Y N
Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Y N
Do you bruise easily? Y N
Liver Disease? (Jaundice, Hepatitis) Y N
Kidney Disease? Y N
Diabetes? Y N
Thyroid Disease? Y N
Arthritis? Y N
Stomach Ulcers or Colitis? Y N
Glaucoma? Y N
Implant place anywhere in body?(Heart Valve, Pacemaker, Hip Knee Y N
Radiation(X-Ray), Treatment for Cancer? Y N
Clicking or popping of jaw joint, Pain near ear, difficulty opening mouth
Grind or Clench teeth ? Y N
Sinus of nasal problems? Y N

ARE YOU USING ANY OF THE FOLLOWING

Antibiotics? Y N
Anticoagulants? Y N
Aspirin or drugs such as Motrin, Aleve or Ibuprofen? Y N
High Blood Pressure Medication? Y N
Steroids? (Cortisone, etc) Y N
Tranquilizers? Y N
Insulin or Oral Anti-diabetic drugs? Y N
Digitalis, Inderal, Nitroglycerin, or other heart drugs?
Please list any and all medications taken, including over-the-counter medications, herbal or holistic remedies, vitamins or minerals:

_____
_____

ARE YOU ALLERGIC TO OR HAVE AN ADVERSE REACTION TO?

Local Anesthesia? (Novocain, etc.) Y N
Penicillin or other antibiotics? Y N
Sedatives, Barbiturates? Y N
Aspirin or Ibuprofen? Y N
Codeine, or other pain killers? Y N
Latex or Rubber Products? Y N
Other Allergies or reactions? Y N
Please list_____
_____
Do you smoke or chew tobacco? Y N
How much per day? _____
Is there any past history of alcohol or chemical dependency or emotional disorder that may effect the care we provide you? Y N
Have you had any serious problems associated with any previous dental treatment? Y N
Have you or an immediate family member had any problems associated with intravenous anesthesia? Y N
Do you have any other diseases, conditions or problems not listed above that you think the doctor should be aware of? Y N
Do you wish to talk with the doctor privately about anything? Y N

FOR WOMEN ONLY

Are you pregnant or is there a chance you may be pregnant? Y N
Are you nursing? Y N
****** 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. Please use appropriate precautions.

Family Physician_____
Phone Number_____

Have you seen a specialist for any health conditions listed? Y N
If so, please give names_____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible, thus the information given above is true and correct to the best of my knowledge. I have had the opportunity to discuss my health history with the doctor.

Signature:_____ Date _____ Doctor's initials _____

Primary Dental Insurance

Subscriber Name_____

Relation to Patient_____Birthdate_____SS#_____

Address (if different from Patient's)_____

City_____State_____Zip_____Phone (____)_____

Person Responsible Employer_____

Employers Address_____Phone (____)_____

Insurance Company_____Phone (____)_____

Member ID #_____ Group # _____

Primary Medical Insurance

Subscriber Name_____

Relation to Patient_____ Birthdate_____ SS#_____

Address (if different from Patient's)_____

City_____ State_____Zip_____Phone (_____)_____

Person Responsible Employer _____

Employer Address_____Phone (_____)_____

Insurance Company_____ Phone (_____)_____

Member ID #_____Group #_____

****We must be aware of all policies that you are covered under at the time of Consultation.**

Failure to provide this Information could result in denials of Insurance Claims which could become patient responsibility**

Authorization for Services

The signature below serves as authorization for services rendered by The Institute of Oral & Maxillofacial Surgery, LLC for the above named patient, and release of information necessary to file Insurance and assign benefits otherwise payable to the policy holder to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by the Insurance carrier and will be billed for all services after 60 days regardless of Insurance status. I also agree to pay all collection fees and court cost in the event of such occurrence. A copy of the signature is valid as the original. The signature below also serves as authorization for The Institute of Oral & Maxillofacial Surgery, LLC to release or receive information for the purpose of patient care/ referral. A copy of the signature is valid as the original.

Patient/ Guardian Signature_____ Date_____

Secondary Dental Insurance

Subscriber Name_____

Relation to Patient_____Birthdate_____SS#_____

Address (if different from Patient's)_____

City_____State_____Zip_____Phone (____)_____

Person Responsible Employer_____

Employers Address_____Phone (____)_____

Insurance Company_____Phone (____)_____

Member ID #_____ Group # _____

Secondary Medical Insurance

Subscriber Name_____

Relation to Patient_____ Birthdate_____ SS#_____

Address (if different from Patient's)_____

City_____ State_____Zip_____Phone (_____)_____

Person Responsible Employer _____

Employer Address_____Phone (_____)_____

Insurance Company_____ Phone (_____)_____

Member ID #_____Group #_____

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Patient/ Guardian Signature_____ Date_____

TRAVEL SCREENING INFORMATION

Optim Health System if following the Centers for Disease Control and Prevention travel careening guidelines. Please complete the following questions.

HAVE YOU OR ANYONE YOU ARE IN CLOSE CONTACT WITH….

Been in contact with anyone that has been diagnosed or is being monitored by the CDC for COVID-19 in the last 30 days?	Yes	No
Traveled out of the country in the last 30 days?	Yes	No
Traveled on a cruise ship in the last 30 days?	Yes	No
If yes, what country did you / they visit? _____		

Are you/ they currently experiencing any of the following symptoms?

Fever (greater than 100.4°F/ 38.0°c)	Yes	No
Severe Headache	Yes	No
Muscle Pain/ Weakness	Yes	No
Diarrhea/ Vomiting/ Abdominal Pain	Yes	No
Respiratory Symptoms / Shortness of Breath	Yes	No
Rash/ Skin Irritation	Yes	No
Unexplained Bleeding or Bruising	Yes	No

Printed Name Signature Date Time

Clinical Staff Notification Required? _____Yes _____No

Language / Translation Line Utilized

Reviewed 11/5/2019, Revised 12/6/2019 Revised 03/06/2019, 07/31/2019, 03/04/2020, 03/06/2020, 03/11/2020

The Institute of Oral & Maxillofacial Surgery

ORAL SURGERY INSTITUTE COVID-19 CONSENT

You are receiving dental care during the events of COVID-19 National Emergency.

Please be advised that there may be risks in being in the proximity of dentist, patients, or staff. We are taking precautions to limit the spread of disease, yet there is still a possibility of transmission.

I, _____ understand that I am receiving oral surgical care during a time of national emergency where the risk of contraction a potential life-threatening virus is at heightened state. I am consenting to being threated by Oral Surgery Institute during this global pandemic and understand that Oral Surgery Institute is taking numerous precautions to ensure my patient safety. Including but not limited to appropriate mask, protective gowns, no patient cross-over, patient and their escorts waiting in cars, no direct contact, protective eye wear and taking temperature upon arrival.

Patient_____

Witness_____

Provider_____

Frank E. Scarborough, D.M.D

145 Traders Way, Suite A, Pooler, Georgia 31322 P: (912) 748-3143 F: (912) 330-5085

Acknowledgement of Privacy Practices

The Institute of Oral & Maxillofacial Surgery, LLC

145 Traders Way, Ste. A

(912)748-3143

My signature confirms that I have been informed of my rights to privacy regarding my protected health information. Under the Health Insurance Act of 1996 (HIPPA). I understand that this information can and will be used to: Portability & Accountability.

- Provide/ coordinate my treatment among different health care providers who may be involved directly or indirectly in that treatment.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities

I Have been informed of my oral surgery provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures pf my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my oral surgery provider has the right to change the **Notice of Privacy Practices** and that I may contact this office at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you or not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____Date_____

Signature: _____

Relationship to patient: _____

*Dependent family members also covered by this acknowledgement:

Office Use Only

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

_____ The patient refused to sign
_____ Communication barriers
_____Emergency situation
_____Other: _____