



South Dayton Oral & Maxillofacial Surgery

Trent L. Tucker D.D.S., M.D
7325 Far Hills Avenue
Dayton, Ohio 45459
(937) 439-1606

Patient Name (Dr. Mr. Mrs. Ms.) _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Age _____ SS# _____ - _____ - _____ Family Dentist _____

Employer/School _____ Occupation/Student _____

Employer Address _____ Phone _____

Guarantor _____ Payment Method: Cash Check Visa/MC/Disc.
(Check one or more) CareCredit Apply for Care Credit

Patient Relationship _____

Home Phone _____ Cell Phone _____ Email _____

Address (if different from patient) _____

Employer Name and Address _____

Work Phone _____ Occupation _____

Spouse Name _____ Spouse Employer _____

Work Phone _____ Occupation _____

Guarantor SS# _____ - _____ - _____ Spouse SS# _____ - _____ - _____

INSURANCE INFORMATION

Dental Insurance _____ Policy# _____ Phone _____

Policyholder _____ Birthdate _____ Employer _____

Secondary Dental _____ Policy# _____ Phone _____

Policyholder _____ Birthdate _____ Employer _____

Medical Insurance _____ Policy# _____ Phone _____

Policyholder _____ Birthdate _____ Employer _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon the completion of each visit. Other arrangements can be made with our office manager depending on special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company. Any unpaid balances after insurance are due within 30 days after payment is received.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named for the benefits otherwise payable to me. I have read the above and understand that I am responsible for all office charges. A 1.5% monthly service charge (18% APR) will be assessed on any unpaid balances after 30 days.

Signature _____ Date _____

Confidential Medical History

Physician's Name _____ Date of last exam _____

Are you under physician's care currently? _____ For what? _____

Women: Are you pregnant or currently trying to get pregnant? _____ Nursing? _____ Taking oral contraceptive? _____

List all **medications** you are presently taking:

List any **hospitalizations** or **surgeries**:

Do you smoke? _____ How much? _____

ALLERGIES: (Check one or more below)

- Penicillin Latex Other _____
- Aspirin Erythromycin _____
- Tetracycline Codeine _____
- Dental anesthetics _____

SYMPTOMS: Check any symptoms you currently have or have had in the past.

General:

- Stomach/intestinal Alcoholism
- Fever blisters Chemical dependency
- Cold sores Psychiatric care
- Depression Chemotherapy
- Dizziness Cancer
- Fainting Radiation treatment
- Headache Tumors/growths
- Migraines Weight loss
- Ulcers Herpes
- Frequent diarrhea Venereal disease
- AIDS Anorexia
- HIV positive Bulimia
- Alzheimer's disease Malignant hypothermia
- Osteoporosis Bone Protecting Drugs

Eyes, Ears, Nose, and Throat:

- Bleeding gums Difficulty swallowing
- Hay fever Loss of hearing
- Persistent cough Sinus problems
- Glaucoma Cataracts

Pulmonary:

- Obstructive sleep apnea Lung Disease
- Shortness of breath Emphysema
- Asthma Tuberculosis
- Chronic bronchitis Frequent cough
- Pneumonia

Nervous System:

- Convulsions Multiple sclerosis
- Epilepsy/seizures Stroke

Endocrine/Glandular:

- Goiter Thyroid disease
- Kidney problems Parathyroid disease
- Kidney dialysis Yellow jaundice
- Liver disease Excessive thirst
- Hepatitis A Diabetes
- Hepatitis B Hypoglycemia
- Hepatitis C Steroid use

Cardiovascular:

- Chest pain Congenital heart defect
- Heart disease Heart murmur
- Heart attack/failure Mitral valve prolapse
- Irregular heartbeat Angina
- Rheumatic fever Artificial heart valve
- Heart pacemaker Heart surgery
- High blood pressure Low blood pressure
- Blood disease Anemia
- Bruise easily Blood transfusion
- Bleeding disorder

Muscle/Joint/Bone:

- Pain, numbness Arthritis
- Facial pain/numbness Artificial joints
- TMJ pain/clicking Fibromyalgia

Other:

Which pharmacy would you like to use?

Name: _____

Street/Zip: _____

*****For Office Use Only*****	
Medical history reviewed with patient:	
Initials	Date
Initials	Date
Comments: _____	

Signature of patient (parent if minor) _____ Date _____

**HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- | | |
|--|-------|
| It was emergency treatment | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign | _____ |
| The patient was unable to sign because | _____ |
| Other (please describe) | _____ |

Signature of Privacy Officer

