Patient Number _____
Office Use Only

Drs. Scheetz & Rekos
Oral & Facial Surgeons of Ohio
THE CENTER FOR DENTAL IMPLANTS

PATIENT REGISTRATION

Please complete this form in its entirety.

○ Mr. ○ Mrs. ○ Miss ○ Dr.

Patient Name _____
Last First Middle Maiden

Preferred Name (if any) _____ Date of Birth _____ Age_____

○ Male ○ Female Patient SSN _____

Marital Status ○ Single ○ Married ○ Divorced ○ Partnered ○ Widowed

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

What is your preferred method of contact? ○ Home Phone ○ Work Phone ○ Cell Phone

May we leave messages regarding appointment reminders? ○ Yes ○ No

Emergency Contact Person _____ Phone _____

Patient Employer _____ Employer Phone _____

Are you a student? ○ Yes ○ No School Name: _____ ○ Full Time ○ Part Time

General Dentist _____ _____
Name Phone

Orthodontist _____ _____
Name Phone

Family Physician _____ _____
Name Phone

Pharmacy _____ _____
Name Phone

Have you or a family member ever been a patient of our practice? ○ Yes ○ No

If yes, name of patient (s) _____

Whom may we thank for referring you to our office?

○ Dentist ○ Orthodontist ○ Internet/Website ○ Family/Friend ○ Other_____

Patient Signature (Parent signature if patient is minor):_____ Date: _____

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FINANCIAL POLICY

Thank you for choosing Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) for your oral & maxillofacial surgery needs. We are committed to providing the services you expect in a safe, friendly, and professional manner.

Patients who do not have medical or dental insurance

Payment is expected in full prior to the services being rendered.

Patients who have verified medical and/or dental insurance benefits

Deposit or full payment (in some cases) is payable prior to the services being rendered. As a courtesy to you, we will file insurance. Any credit due you will be refunded or applied to future services. A predetermination of benefits will be submitted ONLY at your request.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. and Flexible Spending benefit cards or checks are acceptable.
- Care Credit is available for those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association approved commercial line of credit specifically designed for the payment of dental care. To learn more about this option, feel free to speak to the financial office.

*****PLEASE NOTE** Financing options are not available in conjunction with the courtesy discount and/or In-network dental plans.***

Account Refunds

Accounts reflecting a credit balance after insurance payment is received, change of treatment plan, etc. will be refunded via check.

If you arrive on the day of your appointment with no means of payment, we reserve the right to reschedule your appointment.

Please note the following:

- Any quoted fees are an estimate only and are valid for a period of one year.
- The financial obligation for services received is your responsibility and not the responsibility of Oral & Facial Surgeons of Ohio or your insurance carrier.
- Divorced Parents: The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.
- We will file your primary medical and primary dental insurance. We will file to secondary dental insurance should a balance remain on the account after primary payment is received. Filing of secondary medical insurance claims are the patient's responsibility.
- Account balance is due 60 days from the date the services were rendered whether payment has been received from your insurance carrier or not.
- A 1.5% service charge (18% per annum) may apply to past due balances.
- In the event your account becomes delinquent, you may be responsible for any and/or all collection fees (i.e. 35% of account balance sent to collection agency).

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FINANCIAL RESPONSIBLITY

☐ Patient is responsible party *(if you check this box, move on to the signature line below)*

Responsible Party Information
(Parent, Legal Guardian or person that will pay for services rendered)

Name (First) _____ (Last) _____ (MI) ____

Relationship ○ Spouse ○ Parent ○ Other _____

Date of Birth _____ SSN _____

Address (Street) _____ (City) _____ (State) _____ (Zip) _____

Home Phone ( ) _____ Cell Phone ( ) _____

Employer _____ Employer Phone ( ) _____

By signing below I verify that I have read, understand and accept the guidelines and terms stated within in the OFSO Financial Policy and that I am the financially responsible party for this patient account.

_____
Signature of Responsible Party

_____
Print Name

****PLEASE NOTE****

Divorced Parents: The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.

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Oral & Facial Surgeons of Ohio
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INSURANCE INFORMATION

Please complete **all** sections of this form. As a courtesy, we are happy to file insurance claims on your behalf. If this form is not completed in its entirety, we will be unable to file claims. Please have your insurance cards(s) available for our staff to scan into our system. **Please note we will file primary dental, secondary dental and primary medical claims, but we will not file with secondary medical, Medicare, Medicaid or Care Source.**

Primary Medical Insurance

**the subscriber is the holder of the insurance policy*

Insurance Co. Name			Subscriber Name	
Insurance Tel. #			Subscriber DOB	
P.O. Box City St Zip			Subscriber S.S. #	
Employer Name			Identification #	
Tel. #			Group #	

Relationship to patient: ○ Self ○ Spouse ○ Parent ○ Other _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed **Subscriber Sex**: ○ Male ○ Female

Is subscriber address the same as patient address? ○ Yes ○ No

If no, address:_____

Primary Medical Insurance

Insurance Co. Name			Subscriber Name	
Insurance Tel. #			Subscriber DOB	
P.O. Box City, St Zip			Subscriber S.S. #	
Employer Name			Identification #	
Tel. #			Group #	

Relationship to patient: ○ Self ○ Spouse ○ Parent ○ Other _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed **Subscriber Sex**: ○ Male ○ Female

Is subscriber address the same as patient address? ○ Yes ○ No

If no, address:_____

Secondary Dental Insurance

*****Please Note:** We do not file secondary medical claims but we will give you information in order for you to file.*****

Insurance Co. Name			Subscriber Name	
Insurance Tel. #			Subscriber DOB	
P.O. Box City ST Zip			Subscriber S.S. #	
Employer Name			Identification #	
Tel. #			Group #	

Relationship to patient: ○ Self ○ Spouse ○ Parent ○ Other _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed **Subscriber Sex**: ○ Male ○ Female

Is subscriber address the same as patient address? ○ Yes ○ No

If no, address:_____

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THE CENTER FOR DENTAL IMPLANTS

HEALTH HISTORY

The scope of oral & maxillofacial surgery includes the diagnosis and treatment of disease, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Health problems may affect the outcome of treatment. ***Note***Your answers are for our records only and will be considered confidential.*

Are you currently in good health? ◯ Yes ◯ No Have you had any change in your health in the last year? ◯ Yes ◯ No

Height _____ Weight _____ Do you take antibiotics prior to dental treatment? ◯ Yes ◯ No

	Y	N	Date		Y	N	Date
Heart Pacemaker	◯	◯	_____	Hip, Knee or any joint prosthesis	◯	◯	_____
Heart Trouble	◯	◯	_____	Stomach Ulcers	◯	◯	_____
Heart Murmur	◯	◯	_____	Jaundice, Hepatitis, Liver Disease	◯	◯	_____
Heart Attack	◯	◯	_____	Arthritis	◯	◯	_____
Chest Pain (Angina)	◯	◯	_____	Back injury, pain, surgery	◯	◯	_____
Mitral Valve Prolapse	◯	◯	_____	Pain in Jaw Joints	◯	◯	_____
Heart Valve Replacement	◯	◯	_____	Stroke	◯	◯	_____
Rheumatic Fever	◯	◯	_____	Glaucoma	◯	◯	_____
High___/ Low___Blood Pressure	◯	◯	_____	Nervous Disorder	◯	◯	_____
Asthma	◯	◯	_____	Kidney or Urinating problems	◯	◯	_____
Hay Fever, Sinus problems	◯	◯	_____	Are you on dialysis?	◯	◯	_____
Pneumonia	◯	◯	_____	Sickle Cell Anemia	◯	◯	_____
Bronchitis, Chronic Cough	◯	◯	_____	Hemophilia, bleeding tendency	◯	◯	_____
Tuberculosis or other Lung Disease	◯	◯	_____	Other Blood disorder	◯	◯	_____
Emphysema	◯	◯	_____	Tumor or abnormal growths	◯	◯	_____
Radiation Therapy for Cancer	◯	◯	_____	Cancer	◯	◯	_____
Epilepsy	◯	◯	_____	HIV or AIDS	◯	◯	_____
High___/Low___BloodSugar,Diabetes	◯	◯	_____	Blood Transfusion	◯	◯	_____
Thyroid Problems	◯	◯	_____	Malignant Hyperthermia	◯	◯	_____
Faint Easily	◯	◯	_____	Herpes	◯	◯	_____
Lymphatic Disease or Lymph Nodes	◯	◯	_____	Contact Lenses	◯	◯	_____

Describe any medical problems or surgery not listed on questionnaire above _____

_____

_____

_____

Do you currently or have you taken any medications for the treatment of osteoporosis (ie. Fosamax, Actonel, Aredia)?

◯ Yes ◯ No If yes, for how long? _____

Have you ever had cancer treatment that involved bone replacement drugs like the above? ◯ Yes ◯ No

Doctor Initial _____ Date _____

5155 Bradenton Avenue, Suite 100 Dublin, Ohio 43017 phone (614) 764-9455 fax (614) 526-3745 www.omfso.com

Drs. Scheetz & Rekos
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HEALTH HISTORY

PLEASE LIST ALL MEDICINES, PILLS OR DRUGS YOU ARE NOW TAKING:

Including prescription or non prescription drugs, any over the counter medicines, herbal medications, or any recreational or illegal drugs and chemicals you have chosen to take: Remember this information is **CONFIDENTIAL** It is important for us to have this information to treat you safely.

NAME OF DRUG	HOW OFTEN EACH DAY	PURPOSE OF DRUG OR DISEASE BEING TREATED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you need more space please use the backside of this paper.

Do you have any allergies to medicines, foods, or products? ○ Yes ○ No

☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex Rubber ☐ Demerol
☐ Valium ☐ Sodium Pentothal ☐ Aspirin ☐ Shellfish ☐ Eggs ☐ Nuts

Please name other allergies:_____

○ Yes ○ No Do you smoke? Packs per day?_____
○ Yes ○ No Did you smoke in the past? When did you stop?_____
○ Yes ○ No Do you consume alcohol? How much per day?_____ Week? _____
○ Yes ○ No Do you use recreational drugs? ***(This question is asked strictly for your safety)***
○ Yes ○ No Have you used cocaine within the last year? ***(This question is asked strictly for your safety)***
○ Yes ○ No Do you now, or have you ever, used tranquilizers?
When?_____ Why?
○ Yes ○ No Are you now, or have you ever been, treated with cortisone or steroid drugs?
When?_____ Why?_____
○ Yes ○ No Have you ever had trouble with general anesthesia? Describe_____
○ Yes ○ No Have your parents or any of your close relatives had malignant hyperthermia?
○ Yes ○ No Have you been diagnosed with sleep apnea?
○ Yes ○ No Have you ever had excessive bleeding from minor wounds or following extraction of teeth?
○ Yes ○ No Is there anything you would like to discuss in private with the doctor?

WOMEN ONLY:

○ Yes ○ No Are you, or could you be pregnant? How far along?_____
○ Yes ○ No Are you taking birth control pills?
○ Yes ○ No Are you nursing?

Patient Signature_____ **Date**_____

Doctor Initial _____ Date _____

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

ORAL & FACIAL SURGEONS OF OHIO
ACKNOWLEDGEMENT OF RECEIPT OF NOTICEOF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature} {Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

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3-D IMAGING INFORMED CONSENT

Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) uses a **Cone Beam 3-D Dental Imaging System (i-CAT/i-PAN)** to capture digital images.

You may have an i-CAT scan or i-PAN scan during the course of your treatment. The i-CAT scan or i-PAN scan is intended for your doctor to evaluate skeletal, and/or soft tissue structures of the face only.

Our doctors will review the scan in order to treat you for oral and maxillofacial procedures. In addition to our surgeons review of this scan, you have the option to have the entire scan reviewed by a "Medical or Maxillofacial Radiologist", located outside of our practice, to evaluate the remainder of the anatomic structures in your head, face and neck. We will arrange to have this completed for you, if choose this optional service.

The radiologist will charge a fee for this service. This fee may or may not be covered by your insurance carrier. You will be notified of the radiologist's fee prior to review of the scan.

I understand that Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) uses **Cone Beam 3-D Dental Imaging System (i-CAT/ i-PAN),** to capture digital images and that I, or my dependent may have an i-CAT scan or i-PAN scan captured during the course of treatment.

☐ I **do not** wish for the i-CAT/i-PAN scan to be sent for review by a radiologist.

☐ I **would like** the i-CAT/i-PAN scan be reviewed by a radiologist. I realize that I will be responsible for any charges incurred for this review.

_____ _____

Name Date

Drs. Scheetz & Rekos
Oral & Facial Surgeons of Ohio
THE CENTER FOR DENTAL IMPLANTS

CONSENT FOR RELEASE OF INFORMATION

I authorize Oral & Facial Surgeons of Ohio to disclose my information to a third party recipient, such as a spouse, parent, significant other etc., as I designate below. Completion of this form is voluntary. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Address:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following:

- ☐ Information related to my dental/medical treatment
- ☐ Information related to payment of my dental/medical treatment and/or claims
- ☐ Information related to my dental/medical treatment and/or payment of dental/medical claims specifically for the care I received from _____ to _____.

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
(Signature of person giving consent) Current mailing address

_____ _____
(Print name of person giving consent) Date