Patient Registration Form

FOSC
Foothill Oral Surgery Center

About You

The Patient

Last Name_____ First Name_____ Middle Initial____ Nickname_____

Address_____ City_____ State____ Zip_____

Home Phone_____ Cell _____Email_____ SS#_____

Male ☐ Female ☐ Age____ Date of Birth_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Bus. Phone _____

Is patient a full-time college student? Yes ☐ No ☐ School _____ City _____ State ____

Have you or a family member been to our office before? Who? _____ When? _____

Patient Account Information

Person Responsible for Account

Last Name _____First Name_____ Relationship to Patient _____Date of Birth _____

SS# _____ Address (if different from Patient) _____

City _____ State _____ Zip _____ Home Phone _____

Employed by _____ Occupation _____ Cell _____

Business Address_____ City_____ State____ Zip_____ Bus. Phone_____

Dental Insurance Information

Primary Dental Insurance

Dental Inurance Co. Name _____ Phone_____

Insurance Co. Address _____Group #_____

Subscriber's Name _____Relationship to Patient _____ Date of Birth _____

Subscriber's Address (if different than patient) _____ ID# _____

City _____ State_____ Zip _____ Home Phone _____

Subscriber Employed by _____Bus. Phone _____

Is patient covered by additional dental insurance? Yes ☐ No ☐

Secondary Dental Insurance

Dental Insurance Co. Name _____ Phone_____

Insurance Co. Address _____Group #_____

Subscriber's Name _____Relationship to Patient _____ Date of Birth _____

Subscriber's Address (if different than patient) _____ ID# _____

City _____ State_____ Zip _____ Home Phone _____

Subscriber Employed by _____Bus. Phone _____

In Event of Emergency

Person To Contact: Name _____ Relationship to Patient _____

Home Phone _____ Bus. Phone _____ Cell _____

Dental History Information

Who referred you to our office? Name _____

Who is your General Dentist? _____ I have been their patient for _____ mo/yrs

Do your gums bleed when you brush?	Yes □ No □	Do you know about dental implants?	Yes □ No □
Do you have pain or clicking in your jaw joints?	Yes □ No □	Do you know someone who has dental implants?	Yes □ No □
Do you grind or clench your teeth?	Yes □ No □	Are you happy with the way your teeth function?	Yes □ No □
Do you have missing teeth?	Yes □ No □	Are you happy with the way your teeth look?	Yes □ No □
Date of last dental exam with your dentist _____		Are you having pain or discomfort at this time?	Yes □ No □

How would you describe your current dental condition and reason for your visit? _____

Medical Information

Have you been a patient in the hospital during the past two years? Yes □ No □ Why? _____

Have you been under the care of a medical doctor during the past two year? Yes □ No □ Why? _____

Physician's Name _____ Phone _____

Address _____City _____Fax _____

Have you taken any medication/ drug in the past two years? Yes □ No □ List _____

Are you currently taking medication, herbs, or drugs? Yes □ No □ List (include dose and regimen) _____

_____

_____

Are you **SENSITIVE OR ALLERGIC** to any medication or anesthetics? Yes □ No □ List _____

_____

Are you **SENSITIVE OR ALLERGIC** to any of the following? (please circle) LATEX SOY EGGS

Do you smoke /vape or have previous history of use? Yes☐ No☐ Ho many per day _____ How many years? _____

Do you use, or have used recreational drugs? Yes☐ No☐ What drug(s)? _____

Please check YES or NO indicating whether you HAVE HAD or CURRENTLY HAVE any of the following conditions or symptoms.

	Y	N		Y	N		Y	N		Y	N
High Blood Pressure			Cosmetic Surgery			Cancer (Tumor)			Blood Transfusion		
Stroke			Limited Jaw Opening			X-Ray/Cobalt Treatment			Drug Addiction		
Heart Disease			Pain/Noise in Jaw Joints			Chemotherapy			Venereal Disease		
Angina Pectoris			Alcoholism			Arthritis			Cold Sores		
Pacemaker			Emphysema			Rheumatism			Epilepsy or Seizures		
Rheumatic Fever			Persistent Cough			Steroids (Cortisone)			Fainting or Dizzy Spells		
Heart Murmur			Tuberculosis (TB)			Glaucoma			Depression, Nervousness		
Scarlet Fever			Asthma			Bruise Easily			Psychiatric Treatment		
Artificial Joint			Hay Fever			Liver Disease			Blood Disorder		
Anemia			Sinus Trouble			Hepatitis			Hemophilia		
Kidney Trouble			Allergies or Hives			Yellow Jaundice			Sickle Cell Disease		
Ulcers			Diabetes			AIDS			Hypoglycemia		
Porphyria			Thyroid Disease			HIV Positive			Developmentally Disabled		

Do you have any disease or problem not listed above? Yes □ No □ List _____

Do you currently wear contact lenses?	Yes □ No □
Have you ever had any excessive bleeding requiring special treatment?	Yes □ No □
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?	Yes □ No □
Do your ankles swell during the day?	Yes □ No □
Do you sleep with more than two pillows under your head?	Yes □ No □
Have you lost or gained more than 10 pounds during the past year?	Yes □ No □
Are you on a special diet?	Yes □ No □
Have you ever taken or do you take bisphonates (i.e., Fasomax)?	Yes □ No □
Males: Have you ever taken Viagra?	Yes □ No □
Females: Are you pregnant? (Surgery/Medication may cause birth defects/miscarriage)	Yes □ No □
Females: Do you wish to consult your physician to rule out pregnancy?	Yes □ No □
Females: Are you currently using birth control pills?	Yes □ No □

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform this office immediately at the next appointment without fail.

Signature of Patient, Parent, or Guardian _____ **Date** _____

Notice of Privacy Practices

FOSC
Foothill Oral Surgery Center

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- At FOSC we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your information when required by law.
- We may use images of your case for electronic and/or printed publications and posts, for example: Before and After photos of your mouth and teeth for our website or brochure.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use the address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have a right to receive a copy of this notice.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC, 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Office (949) 470-3672.

Acknowledgement

I have received a copy of the FOSC Notice of Privacy Practices.

Printed Name: _____

Signature: _____ Date: _____

My preferred method of communication (circle one): email or phone: home work mobile

Preferred email address or phone # : _____

Financial Policy

FOSC
Foothill Oral Surgery Center

_____ Payment is due when services are rendered. If you have dental insurance, it is our policy to collect all co-payments and deductibles at the time of service. There is a $50.00 returned check fee.

_____ A credit card is required to be on file to schedule appointments. It will be billed a $50 cancellation fee if a scheduled appointment is missed without at least 2 business days advance notice. Example: An appointment on a Monday, requires cancellation and rescheduling **by end of day Wednesday the week before**, in order to not be assessed the cancellation fee.

_____ A credit card is also used to guarantee all amounts due on your account. If you do not wish to use your credit card on file to guarantee your account, we can not extend credit to you in the form of an outstanding insurance receivable. If you do not leave a credit card to guarantee your account, you will need to pay in full for all services at the time they are rendered.

_____ If you do leave a credit card to guarantee your account, once the insurance has paid, or when 60 days has passed, whichever comes first, any remaining balance due on your account will be paid with the credit card on file. Once your account is paid in full, a statement and any applicable receipts will be sent to you. If insurance pays us after your credit card is used to pay your balance, you will be reimbursed.

_____ In order to keep from having to pay the entire receivable balance after 60 days, we suggest you stay in contact with your insurance company. Encourage them to pay in a timely manner. Please understand that your insurance coverage is a contract between you and your insurance company, not this office. We cannot take responsibility for large out of pocket costs, special claim forms, or delays and denials. You are ultimately responsible for payment of your account in full and your credit card on file will be used to fulfill that responsibility.

_____ If you have questions regarding your insurance coverage, please discuss it with your insurance company prior to your visit. We are happy to assist you in determining what benefits are available to you, but this is not a guarantee of payment by the insurance company or a pre-authorization of benefits, and does not supplant the need for you to contact your insurance company directly to determine your benefits. Filing an insurance claim is a service provided without charge but in no way relieves you of responsibility for your bill.

By signing this policy, you acknowledge that you have read and understand this agreement and are accepting primary responsibility for all services rendered. You also give us authorization to charge the credit card listed above for any balances due on your account after your insurance has paid, or when 60 days has lapsed from the time service was rendered, whichever comes first. In the event, the above credit card is declined, interest will accrue on the account balance at the rate of 1% per month commencing the day the transaction was denied. If you do not leave a credit card to guarantee your account, you will need to pay in full for all services rendered at the time they are rendered and no credit will be extended to you in the form of an insurance receivable.

Responsible Party's Signature _____ Date_____

INSURANCE AUTHORIZATION – SIGNATURE ON FILE.

I hereby authorize Foothill Oral Surgery Center to affix my name to all insurance submissions, documents and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me. I also authorize payment of healthcare benefits otherwise payable to me, directly to Foothill Oral Surgery Center. I agree I am responsible for all charges and services not paid by my insurance company. A copy of this authorization may act as an original.

Patient or Insured's Signature _____ Date_____

CREDIT CARD ON FILE FOR PURPOSES OUTLINED ABOVE:

Responsible party (Name on Credit Card) _____

M/C Visa Disc AMX Credit Card # _____

Exp. Date _____ CID _____

CREDIT CARD HOLDER SIGNATURE _____ Date_____