THE FACIAL SURGERY CENTER

ORAL SURGERY & DENTAL IMPLANTS

EDWARD J. HALUSIC, D.M.D.

PATIENT QUESTIONNAIRE

Name_____DOB_____Date_____

Address_____

City_____State_____Zip_____

Home Phone Number_____Cell Phone_____

Patient Social Security #_____E-Mail_____

Closest relative not living with you_____ Phone #_____

Is the patient employed? _____Yes ____ No Is the patient a student? _____Yes _____ No

Employer_____Type of work_____

Hobbies_____

Whom may we thank for referring you?_____

Have you or any family member ever been treated at The Facial Surgery Center? _____Yes _____No

If yes, who_____

Dental Insurance: Primary	**Dental Insurance: Secondary**
Name & address of Insurance Co: _____ _____ Employer_____ ID#_____Group#_____ Subscriber's SS#_____ Address_____ Phone_____ Relationship to Patient_____ **Medical Insurance: Primary**	Name & address of Insurance Co: _____ _____ Employer_____ ID#_____Group#_____ Subscriber's SS#_____ Address_____ Phone_____ Relationship to Patient_____ **Medical Insurance: Secondary**
Name & address of Insurance Co: _____ _____ Employer_____ ID#_____Group#_____ Subscriber's SS#_____ Address_____ Phone_____ Relationship to Patient_____ **Medical Insurance: Primary**	Name & address of Insurance Co: _____ _____ Employer_____ ID#_____Group#_____ Subscriber's SS#_____ Address_____ Phone_____ Relationship to Patient_____ **Medical Insurance: Secondary**

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HEALTH QUESTIONNAIRE

Name _____ Date_____

Birthdate_____Age_____ Sex_____Height_____Weight_____Marital Status _____

Who is your general dentist? _____

Are you seeing any other dental specialist? _____

Who is your family physician? _____

Please list any surgeries or previous illnesses: _____

_____

_____

Have you had or currently have any of the following? If yes, please circle Y for YES or N for NO.

A. Stroke	Y / N	O. Arthritis	Y / N
B. Heart Murmur	Y / N	P. Stomach Ulcers	Y / N
C. Rheumatic Fever,	Y / N	Q. Kidney Trouble	Y / N
D. Rheumatic Heart Disease	Y / N	R. Tuberculosis	Y / N
E. Asthma	Y / N	S. Anemia	Y / N
F. High Blood Pressure	Y / N	T. Venereal Disease	Y / N
G. Heart Attack	Y / N	U. Abnormal Bleeding	Y / N
H. Chest Pain	Y / N	V. Cancer	Y / N
I. Shortness of Breath	Y / N	W. AIDS	Y / N
J. Emphysema	Y / N	X. Tested HIV Positive	Y / N
K. Thyroid Disease	Y / N	Y. Porphyria	Y / N
L. Seizures	Y / N		
M. Diabetes	Y / N		
N. Hepatitis, Jaundice, Liver Disease	Y / N		

Are you taking any blood thinner medication? _____

Are you currently taking or previously taken a bisphosphonate medication or any other drug for Osteoporosis? If so please list the drug, duration, frequency etc…

_____

Please list **all** medications, vitamins, and supplements: _____

_____

Do you have a prosthetic joint (i.e. knee, hip, etc.)? _____

Do you have a prosthetic heart valve? _____

Do you have a latex allergy? _____ Reaction?_____

Are you allergic to any medications? If so, please list: _____

_____

Have you or any other member of your family had a bad reaction to any anesthetic? If yes, please explain:_____

Do you currently smoke or use tobacco? Please indicate below along with frequency or amount per day and total number of years:

Smoke_____ Tobacco_____ Snuff_____ Frequency/ duration_____

Have you previously used tobacco or quit smoking? _____ For how long?_____

Women: Are you pregnant? _____

Men: Are you taking any erectile dysfunction medication? _____

Is there any other important information pertaining to *your* health history or general well-being so we can provide you with the best possible care? If so, please explain:

_____

_____

Patient's, Parent, or Guardian's Signature: _____

Reviewed by: _____Date:_____

(Assistant please date and initial when information is updated)

Updated:_____ Updated:_____

Updated:_____ Updated:_____

Updated:_____ Updated:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

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

_____
(Please Print Name)

_____
(Patient/Parent/ or Legal Guardian Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgment 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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Written Financial Policy

Thank you for choosing The Facial Surgery Center. Our primary mission is to deliver the best and most comprehensive treatment available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:
- Cash
- Check
- Visa/MasterCard/Debit
- Care Credit (for our cash patients)

    - NO INTEREST[1] Payment plans[2] from Care Credit
        - Allow you to pay over time with NO INTEREST[1]
        - Convenient, low monthly payment plans also available
        - No annual fees or pre-payment penalties

Please note:

To secure your surgery date, it is the policy of The Facial Surgery Center that any out of pocket expenses and co-insurances greater than $300.00 be paid two weeks prior to surgery.

Any patients with out-of-network insurances are considered cash patients. However, we will submit a claim on your behalf for possible reimbursement to you.

The Facial Surgery Center charges a $50.00 fee for any returned checks for insufficient funds. In the event you use your credit or debit card for payment and you cancel your appointment you will be refunded the amount charged minus any fees incurred by The Facial Surgery Center from your credit/debit card company.

I understand that because of unexpected circumstances, the treatment, the fees for treatment, and/or the materials may require some changes after the actual care has begun. I understand that such changes may incur additional fees and I will assume the financial responsibility for such fees.

We will work with your insurance companies to maximize your insurance benefits. You will be responsible for any deductible, coinsurance or co-payments that apply to your policy.

Balances after insurance that are over 120 days will be turned over to collection if not paid in full.[3]

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please print)

[1] If paid within promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2] Subject to credit approval.
[3] However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Date: _____

Patient Name: _____

An panoramic X-ray is needed for diagnosing and treatment purposes. I understand that refusal of an X-ray may impact my treatment plan/treatment at The Facial Surgery Center.

_____ _____

Patient Signature **Date**

_____ _____

Employee Signature **Date**