CENTRAL MARYLAND ORAL AND MAXILLOFACIAL SURGERY, PA
10710 Charter Drive, Suite 330 Columbia, MD 21044

Central Maryland
Oral and Maxillofacial Surgery, P.A.

Date: _____

PATIENT INFORMATION

Patient Name: _____ SSN: _____
First M.I. Last

Date of Birth: _____ Age: _____ Sex: _____

Patient Address: _____
City State Zip code

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Name of Employer: _____ Occupation: _____

Employer Address: _____
City State Zip code

Marital Status: Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ (Check One) Student: Yes ○ No ○

Spouses Name: _____ Social Security # _____

Spouse's Employer: _____ Work Phone # _____

Employer Address: _____
City State Zip code

IF PATIENT IS A MINOR — PARENT INFORMATION

Parents Name: _____ Social Security # _____

Parents Address: _____
City State Zip code

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Parents Employer: _____ Occupation: _____

Employer Address: _____
City State Zip code

INSURANCE INFORMATION

DENTAL- PRIMARY

Insurance Company: _____
Address: _____
Policy # _____ Group # _____
Policy Holders Name: _____
Address: _____
DOB: _____ SSN: _____

DENTAL-SECONDARY

Insurance Company: _____
Address: _____
Policy # _____ Group # _____
Policy Holders Name: _____
Address: _____
DOB: _____ SSN: _____

MEDICAL- PRIMARY

Insurance Company: _____
Address: _____
Policy # _____ Group # _____
Policy Holders Name: _____
Address: _____
DOB: _____ SSN: _____

MEDICAL-SECONDARY

Insurance Company: _____
Address: _____
Policy # _____ Group # _____
Policy Holders Name: _____
Address: _____
DOB: _____ SSN: _____

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Do you have or have you had any of the following?

	YES	NO
1. Heart Murmur Is premedication necessary?	○	○
2. Heart Problems/ Chest Pain	○	○
3. Rheumatic Fever	○	○
4. High Blood pressure	○	○
5. Stroke	○	○
6. Bleeding Disorder- If so explain	○	○
7. Fainting	○	○
8. Hepatitis/ Jaundice/ Liver Disease	○	○
9. Arthritis	○	○
10. Tuberculosis	○	○
11. Diabetes	○	○
12. Epilepsy	○	○
13. Porphyria	○	○
14. STD / HIV / AIDS	○	○
15. Herpes	○	○
16. Asthma/Bronchitis/Emphysema	○	○
17. Have you had a cold recently?	○	○
18. Contact Lenses/ Glasses	○	○
19. Pregnant	○	○
20. Glaucoma	○	○

	YES	NO
21. Thyroid Disease	○	○
22. Kidney Disease	○	○
23. Artificial Joint/Valve	○	○
24. TMJ/ Jaw Disorders	○	○
25. Psychiatric Care	○	○
26. Sinus Problems	○	○
27. Have you taken any of the cortisone medicines regularly within the last six months?	○	○
28. Have you ever had an allergy or bad reaction to penicillin or other antibiotics?		
a. Penicillin or other antibiotics?	○	○
b. Food	○	○
c. Local anesthetic?	○	○
d. General anesthesia	○	○
e. Other medications? If so, what?	○	○
29. Have you ever had surgery, x-ray, cobalt or radium treatments for a growth or tumor?	○	○
30. Do you have any sores in your mouth or anywhere else that have been there for 10 days or longer?	○	○
31. Do you smoke? If so, how much?	○	○
32. Have you used illicit drugs in the past 12 months?	○	○
33. Have you ever taken weight loss drugs?	○	○

NOTE: It is especially important for us to know if you are taking tranquilizers, phenobarbital, or dilantim: any medicine to prevent blood clots: any of the cortisone medicines: insulin: or blood pressure or heart medicine.

Please list all medications you are taking now (prescription and over the counter): _____

Please list all medications you have taken within the last 6 months: _____

When was your last complete physical? _____ Have you been ill recently? _____

Regular Physician: _____ Phone #: _____

Are you under the care of a physician for any condition? If so, what is the condition you are being treated for? _____

Are there any other medical problems or information which is not listed above that we should be aware of? _____

Were you referred? YES ○ NO ○ By Whom? _____

Regular Dentist: _____ Recent X-rays? YES ○ NO ○

Date of last dental visit: _____

Use the space below to briefly explain the reason for your visit today: _____

Person to contact in case of emergency: _____ Home #: _____ Work/Cell#: _____

ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. ALL SERVICES ARE RENDERED TO THE PATIENT AND ARE CHARGED DIRECTLY TO THE PATIENT. INSURANCE FORMS SUPPLIED BY THE PATIENT WILL BE COMPLETED WITH INFORMATION CONCERNING DIAGNOSIS AND TREATMENT NECESSARY TO EXPEDITE INSURACE PROCESSING. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE

_____ _____

Signature of patient/ Responsible person Date

_____

Reviewed by

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FINANCIAL AGREEMENT

PLEASE READ CAREFULLY AND SIGN AND DATE WHERE INDICATED

THIS IS A CONTRACT

IN-NETWORK INSURANCE:

It is the financial policy of Central Maryland Oral and Maxillofacial Surgery, P.A. ("CMOMS") to bill in network insurance carriers for services rendered; as well as collect patient co pay's, file coinsurance or collect the full fee, when appropriate. It is the guarantor's responsibility or other financially responsible person to completely understand the insurance policy and terms of coverage. CMOMS must receive all pertinent and correct information in regards to the insurance policy and subscribers so we can properly submit the insurance claim. CMOMS as a courtesy will assist in verifying benefits; CMOMS is not responsible for determining whether there is insurance coverage or the terms of coverage, this is the guarantor's responsibility. CMOMS is not responsible for your insurance. If the insurance company denies coverage or declines payment, it is the guarantor's responsibility to pay the full balance, and the guarantor agrees to pay CMOMS the full cost of treatment if insurance is declined or denied for any reason.

OUT-OF-NETWORK INSURANCE:

If the patient has out-of-network insurance, the guarantor is responsible for paying the entire cost of the services provided by CMOMS. However, it is also the financial policy of CMOMS that, as a courtesy, we will submit an insurance claim on behalf of the patient to out-of-network insurance carriers after services are provided. CMOMS must receive all pertinent and correct information in regards to the insurance policy and subscribers so that it can properly submit the insurance claim. It is the responsibility of the patient and guarantor to provide us that information. The out-of-network insurer may send the payment and/or any correspondence directly to the guarantor. It is the guarantor's responsibility to forward this payment and/or information to CMOMS. Please sign the check on the back with your name and write "Pay to the order of Central Maryland Oral and Maxillofacial Surgery, P.A." under your name. Mail the check and a copy of the paper (explanation of benefits) that was enclosed in the envelope to:

Central Maryland Oral and Maxillofacial Surgery, P.A.
10710 Charter Drive
Suite 330
Columbia, MD 21044

If there is a secondary insurance policy and an outstanding balance, as a courtesy, we will send the explanation of benefits and claim to the secondary insurance company, if applicable. Any unpaid balance remains the guarantor's responsibility. If an insurance payment is received by CMOMS, and the balance has been paid in full, CMOMS will issue a payment to the correct party for the amount CMOMS received in excess of full payment.

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CMOMS will send the guarantor monthly statements, designating the responsibilities of the insurance companies and the guarantor. However, payment by the guarantor to CMOMS for our services is due in full within 60 days from when services are rendered. If payment is not received within 60 days from the date of service, CMOMS reserves the right to transfer the account balance to an outside collection agency or attorney or to take such other steps as deemed necessary to collect amounts due. If the account is not paid as required, in addition to the amounts owed for treatment, the guarantor agrees to pay CMOMS's actual collection costs and expenses, including, but not limited to its reasonable attorneys' and paralegal fees. Interest shall accrue on unpaid amounts at 10% per annum on the amount outstanding from the date due until paid in full.

By signing this Financial Agreement, the undersigned guarantor acknowledges that he or she has been fully informed of the collection policy of CMOMS and understands and agrees that he or she is fully responsible for paying for CMOMS's services, as set out in this Financial Agreement, regardless of insurance status. The guarantor agrees that if a balance remains, any payment received by a guarantor from an insurer for services provided by CMOMS will be promptly forwarded by the guarantor to CMOMS.

I HAVE CAREFULLY READ THIS ENTIRE AGREEMENT AND I UNDERSTAND IT COMPLETELY.

Guarantor's Printed Name: _____

Guarantor's Signature: _____

Date: _____

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PATIENT'S SIGNED STATEMENTS
(PATIENT/GUARDIAN SIGNATURES)
(PLEASE READ EACH SECTION CAREFULLY—SIGN & DATE -WHERE INDICATED)

1. This office makes every reasonable attempt to keep **all** patient health information confidential. This office has a complete set of privacy practices available to all patients. An abbreviated version of the privacy practices is posted in our waiting room. The complete set is available upon request. I am aware of the privacy practices.

Patient Signature: _____ Date: _____

2. Every patient's signature at the bottom of the health information sheet gives us signed consent to use the patient's information to process insurance claims, and share pertinent health information with other health care providers for the sole purpose of caring for our patients this may be done by phone, electronic billing, mail, or faxes. At times, other parties may ask for your information (attorneys, employers, claim agents). This information will not be disclosed unless we have signed authorization listing the party that you wish to receive the documentation. The authorization if for a onetime event only. Your signed authorization, date, and party information will be kept on file.

Patient Signature: _____ Date: _____

3. There may be situations where patients may request copies of their records. The office would need a written request signed by the patients and/or guardian 30 days before the issue of records. A photocopying fee of $.25 per page will be collected when the request is made. The doctor's notes are handwritten, therefore, a. consultation fee of $70.00 will be charged to the patient for the doctor to translate his notes upon receipt of the record. This would be due at the time the translation his notes upon receipt of the record. This would be due at the time the translation is scheduled. If the patient would like to view the records without photocopying, the patient will be charged $70.00 translation consultation due when the consultation is scheduled.

Patient Signature: _____ Date: _____