Welcome To Colorado West Oral & Maxillofacial Surgery

PATIENT INFORMATION

DATE _____

☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** **First Name** _____ **M.I.**_____ **Last Name** _____

Preferred Name _____ **Gender**: ☐ Male ☐ Female ☐ Other **Social Security #**_____

Birthdate _____ **Age** _____ **Email Address** _____

Address_____ **City** _____

State_____ **Zip**_____ **Phone** _____ ☐ Cell ☐ Landline

Emergency Contact _____ **Phone** _____

Referred By _____ Have you, or your family, ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ **Orthodontist** _____ **Medical Doctor** _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other _____
(If self, skip to next section)

_____ ____ _____ _____ _____
First Name M Last Name SS# Birthdate

_____ _____ _____ _____ _____
Billing Address City State Zip Phone

PRIMARY DENTAL INSURANCE

Insurance Name _____

Address _____

City_____ State _____ Zip_____

Employer _____

ID #_____ Group #_____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

PRIMARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID #_____ Group #_____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

SECONDARY DENTAL INSURANCE

Insurance Name _____

Address _____

City_____ State _____ Zip_____

Employer _____

ID #_____ Group #_____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

SECONDARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID #_____ Group #_____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

ACCIDENT RELATED?

Is this visit related to an accident? ☐ Yes ☐ No; Date of Accident _____

If Yes, what type? ☐ Automobile ☐ Work Related ☐ Other_____

Insurance company handling the claim _____ Claim # _____

Name of Attorney/Adjustor _____ Telephone Number (_____) _____

Patient Name_____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records and will be considered confidential.

	Yes	No
Height: **Weight:** **Do you consider yourself to be in good health?**	☐	☐
Are you under the care of a physician?	☐	☐
Have you had surgery in the past?	☐	☐
If yes, please list:		
Do you take an antibiotic prior to dental appointments due to a replacement heart valve or joint replacement?	☐	☐
Are you **ALLERGIC** to any medications, or have a **latex** allergy?	☐	☐
If yes, please list:		

SOCIAL HISTORY

Do you use, or have you ever used tobacco or vaping products? ☐ Never ☐ Former Use - How long? Date quit: ☐ Current Use – How Much: How Long:

How often do you drink alcohol? ☐ Never ☐ Current Use Per Week: ☐ Former Use

Marijuana Use? ☐ Yes ☐ No How often?

Recreational Drug Use? ☐ Yes ☐ No

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

- ☐ ADHD
- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anesthesia Problems (self / family history)
- ☐ Anxiety/Depression
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ COPD
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Enlarged Prostate
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ GERD
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other _____
- ☐ **NONE OF THE ABOVE**

Are you NOW taking:	PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:
Blood Thinners? ☐ None ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ Aggrenox ☐ Xarelto ☐ Eliquis ☐ Other	**Medication Name(s)**
Bone Density Medications (bisphosphonates)? ☐ None ☐ Fosamax ☐ Boniva ☐ Xgeva ☐ Zometa ☐ Aredia ☐ Other	

FOR WOMEN ONLY:

Is there a possibility of pregnancy? ☐ Yes ☐ No If **yes**, expected delivery date: _____

Are you Nursing? ☐ Yes ☐ No

Are you on birth control? ☐ Yes ☐ No

Please note: Antibiotics may alter the effectiveness of birth control pills

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **(Parent or Guardian if minor)** _____ **Date:** _____

Patient Name_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

Patients without insurance are requested to pay in full at the time the service is provided, unless other arrangements have been made.

If you have any dental and/or medical insurance, we will be happy to submit the claim on your behalf. 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. You are ultimately responsible for all charges incurred. 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 for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

For your information, our office is contracted with Delta Dental Premier and BCBS Grid+/Complete Dental Plans. For all other insurance carriers, Dr. Kelly and Dr. Reece are out-of-network providers. Your insurance may not pay for services provided to you by our facility, or may reimburse at a reduced rate.

In addition to cash and checks, we accept all major credit cards. Returned checks will be subject to additional fees. We are pleased to offer financing for your surgery through Care Credit or Alphaeon Credit. If you are interested in either of these options, please ask our staff for more information prior to scheduling your surgery.

This signature is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have also been given the opportunity to ask any questions I may have regarding this notice.

I also understand that any correspondence I receive from this office by mail or any information I request to be sent by email or facsimile, may be viewed by a 3rd party. By signing below I understand and accept the risk of these types of correspondence.

I allow this office to give my information to or answer any questions from (please check and provide the name for all that apply):

( ) Spouse _____

( ) Parent _____

( ) Child _____

( ) Other _____
(Please Specify)

( ) None _____

Signature of patient: (Parent or Guardian if minor) _____ **Date:** _____

FOR OFFICE USE ONLY

D. Cameron Reece, DMD, MD
Stephen S. Kelly, DMD
Colorado West Oral and Maxillofacial Surgery

Agreement to Receive Electronic Communication

Patient Name _____

Person to contact for appointments *if different than patient*:

Name: _____ Relationship: _____

Colorado West Oral & Maxillofacial Surgery can communicate with our patients electronically via e-mail and/or text messaging regarding appointments.

When you provide this information to us, it is only used to communicate with you. We do not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

☐ **I consent to receive electronic notifications for confirming, rescheduling, or cancelling my appointments. My most preferred method of electronic communication is:**

☐ Text messaging # _____

☐ Email _____

☐ **I do <u>not</u> wish to be contacted by either text messaging or email.**

I am aware a third-party automated system is used and that there is some level of risk that third parties might be able to read unencrypted emails. I agree that I am responsible for providing the practice any updates to my email and/or phone numbers.

I can withdraw my consent to electronic communications at any time by calling our office at (970) 245-2222, or by emailing cathy@cowestoms.com

Signature: _____ Date: _____