PATIENT INFORMATION:

Name: ________________________________ Nickname:______________________ Date:_________________

Date of Birth:______________________Social Security #:______________________ Marital Status: _________

Age:________ Height:________ Weight:________Gender:________

Mailing Address:___________________________ City:__________________ State:_________ Zip Code:_____________

Home Phone:______________________ Cell Phone:____________________ E-mail: ____________________________

Name of Spouse, Parent, Emergency Contact:________________________________ Phone: ______________

Employer:_________________________Work Phone:__________________Occupation: _________________________

Who is your: Dentist/Orthodontist:______________________ Physician: ______________________________

Who were you referred by?_________________________ Preferred Pharmacy:__________________________________

Reason for referral: ____

Do you have dental insurance? YES NO Would like the initial claim to be filed by Kerrville OMS? YES* NO
***request Dental Insurance Verification form**

HEALTH HISTORY:

Are you in good health? Yes No

Are you receiving any medical care currently? Yes No

If yes, specify ____

History of Surgery ____

Are you taking any medications currently or occasionally to include prescription, over the counter, supplements?

If yes, list ____

Are you allergic to any medications or food, if so what type of reaction?

If yes, list ____

Check all that apply:

_____Any heart ailment
_____High blood pressure
_____Take blood thinners
_____ Any bleeding tendency
_____Any blood disease
_____Lung disease, COPD, asthma
_____Smoking, past or present
_____ E-cig/Vaping, past or present
_____ Recreational Drugs, past or present
_____ Alcohol consumption, past or present
_____Hepatitis or liver disease
_____ Kidney disease
_____Glaucoma or other eye disorders
_____Tuberculosis

_____Cancer
_____Head or neck radiation treatments
_____Diabetes, A1C______
Average glucose_____
_____ Sinus problems
_____ Pregnant or nursing
_____Rheumatic fever
_____Seizures
_____Artificial joint replacement,
Date?___________________
_____Broken jaw or facial trauma
_____Thyroid Hypo- or Hyper-
_____HIV or AIDS
_____Other:

Patient's Initials __________

FINANCIAL AGREEMENT:

I understand that payment in full is expected at time of service. Payment arrangements must be discussed prior to treatment.

INSURANCE PLANS:

Payment is due in full at each visit. Dr. Lussier is not a contracted provider for any insurance plans.
Kerrville OMS does not bill medical insurance nor Medicare/Medicaid. As a courtesy**,** Kerrville OMS will file an initial dental claim on the patient's behalf with information provided by the patient or policy subscribers. The reimbursement for the services provided would be based on your insurance carrier's guidelines. Your signature below is your authorization for the release of information required by your insurance carrier to process claim(s) submitted on your behalf.

COMPLIANCE WITH ALL PRE-OPERATIVE AND POST-OPERATIVE INSTRUCTIONS WILL BE IMPORTANT FOR A SUCCESSFUL EXPERIENCE AND SUCCESSFUL SURGERY. NON-COMPLIANCE MAY RESULT IN A POOR SURGICAL OUTCOME, ADDITIONAL FEES AND/OR SURGERY, AND DISMISSAL FROM THE PRACTICE.

ACKNOWLEDGEMENT- RECEIPT OF PRIVACY PRACTICE NOTICE:

The privacy and protection of your patient information is of the utmost importance to Kerrville OMS. As required by the Federal Health Insurance Portability and Accountability Act (HIPAA) Regulations, a Notice of Privacy Practices must be provided by all healthcare providers to their patients. A copy will be provided upon request. It is available on our website and accompanies the new patient paperwork. Kerrville OMS reserves the right to modify the privacy practices outlined in the notice.

I hereby authorize my medical and dental providers to release my protected health information relevant to my medical/dental history which may influence or benefit my planned surgery at Kerrville OMS. This authorization allows communication to and from Kerrville OMS via phone, fax, email, or written correspondence. I also authorize the following friends or family members to be informed of my care should they inquire on my behalf:

Name: ____________________________ Relationship: _________________ Phone: ______________________

Name: ____________________________ Relationship: _________________ Phone: ______________________

To the best of my knowledge, all the information I have provided is true and correct. I have read and understand the financial policy and have received or have been offered a copy of the Patient Privacy Practices. By my signature, I agree to abide by the policies and guidelines of Kerrville OMS.

____________________________________ ______________________

Signature of Patient or Legal Representative Date

____________________________________ ______________________

Printed Name of Patient or Legal Representative Relationship

Patient's Initials __________