



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: _____
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 you like the initial claim to be filed by Kerrville OMS? YES* NO

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, CBD products?
If yes, list _____
Are you allergic to any medications or food, if so what type of reaction?
If yes, list _____

Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Any heart ailment | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Head or neck radiation treatments |
| <input type="checkbox"/> Take blood thinners | <input type="checkbox"/> Diabetes, A1C _____ |
| <input type="checkbox"/> Any bleeding tendency | Average glucose _____ |
| <input type="checkbox"/> Any blood disease | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Lung disease, COPD, asthma | <input type="checkbox"/> Pregnant or nursing |
| <input type="checkbox"/> Smoking, past or present | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> E-cig/Vaping, past or present | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Recreational Drugs, past or present | <input type="checkbox"/> Artificial joint replacement, |
| <input type="checkbox"/> Alcohol consumption, past or present | Date? _____ |
| <input type="checkbox"/> Hepatitis or liver disease | <input type="checkbox"/> Broken jaw or facial trauma |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid Hypo- or Hyper- |
| <input type="checkbox"/> Glaucoma or other eye disorders | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: |



FINANCIAL AGREEMENT:

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

INSURANCE PLANS:

Dr. Lussier is not a contracted provider for any insurance plans. Payment in full is due at each visit.

As a courtesy, Kerrville OMS will file a dental claim on the patient's behalf. 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 any claim(s) submitted on you or your dependent's 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.

TO HELP SERVICE YOU BETTER WE OFFER SMS (text) FOR APPOINTMENT REMINDERS, INSTRUCTIONS AND OTHER IMPORTANT UPDATES. BY SIGNING BELOW I CONSENT TO RECEIVING SMS (text) FROM KERRVILLE OMS. (Message & data rates may apply, Messaging frequency may vary, I may opt out at any time by replying STOP.)

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, SMS (text) 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