

# Pasqual Oral & Maxillofacial Surgery: Registration Forms

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## Welcome To Our Practice!

Patient Name:			Date of Birth			
Street Address:			Apt./Unit #:	City:	State:	Zip Code:
SSN			Home #			
If Child, Parent's Name			Cell #			
E-mail			Referring Dentist			
Pharmacy			Location / Phone Number			

## DENTAL INSURANCE

Dental Ins. Name	Member ID #
Policy Holder	Policy Holder Date of Birth

## MEDICAL INSURANCE

Medical Ins. Name	Member ID #
Policy Holder	Policy Holder Date of Birth

**AUTHORIZATION:** The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize my surgeon and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment. I understand that I am financially responsible to John R. Pasqual, D.M.D., P.A. for any charges incurred by the above named patient, and promise to pay promptly, the amount of such charges which are not paid by any insurance carrier for any reason. Failure to pay in a timely manner may result in application of service charges to my account, or make me financially responsible for any charges incurred to collect my account, including court cost, attorney fees and up to 15% of my balance for collection agency fees. I authorize release of any information relating to this claim to 3<sup>rd</sup> party payors. I hereby authorize direct payment to John R. Pasqual, D.M.D., P.A. of the insurance benefits otherwise payable to me.

Signature of Patient (Parent or Guardian if minor)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**Medical History**

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current medications:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:**

- Penicillin                       Sulfa                       Latex  
 Codeine                       No Known Allergies                       Other

**Other Allergies:**

\_\_\_\_\_

**Primary Care Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please list any major illnesses, hospitalizations or surgeries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please indicate if you have a history of taking any of the following for osteoporosis/cancer.**

	Yes	No	Duration
Aredia			
Reclast (Zometa)			
Proilia (Denosumab)			
Boniva			
Avastin			
Fosamax (Alendronate)			
Actonel			
XGEVA			

**Substance history:**

	Yes	No
Tobacco Use		
Narcotic/Substance/Chemical Dependency		
Alcohol Dependency		

Please indicate if you have a history of any of the following:

	Yes	No
Heart Disease		
Mitral Valve Prolapse or Valve Disease		
Palpitations / Irregular Heart Beats		
Pacemaker or Stents		
Rheumatic Fever / Endocarditis		
High / Low Blood Pressure		
High Cholesterol		
Heart Murmur		
Chest Pain, Heart Attacks		
Stroke, TIA		
Bronchitis		
Asthma		
Ulcers / Acid Reflux		
Emphysema / Lung Disease		
Pneumonia		
Shortness of Breath		
Liver Disease		
Kidney Disease		
Steroid use or Immunosuppressant		
TMJ problems		
Jaw clicking / Popping		
Osteopenia / Osteoporosis		
Anemia		
Bleeding Tendencies		
Blood Transfusions		
Cancer or Metastasis		
Chemotherapy or Radiation Therapy		
Alzheimer's / Dementia		
Convulsions / Seizures		
Diabetes		
Sinus Disease or Allergies		
Glaucoma		
Hepatitis A, B, C		
STD / Herpes / HPV		

HIV / AIDS		
Prosthetic Joint (hip, knee etc...)		
Psychiatric treatment		
Emotional Disorder		
Thyroid Disease		
Tuberculosis		
Is there a chance you are pregnant?		
Breast Feeding / Nursing		
Sleep Apnea / Snoring		

**Office Use Only:**

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Signature of Patient (Parent or Guardian if minor)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form**

I understand that as a part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of these uses and disclosures of my health information. I understand that: \*I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement. \*This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Please list any individuals (family, friends, etc.) that you authorize us to speak to regarding your appointment, treatment, and billing.

Name(s) & Relationship to Patient	Phone Number(s)
_____	_____
_____	_____
_____	_____

I am giving John R. Pasqual, D.M.D., P.A. the authority to access my medical and dental records if necessary.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and other Healthcare Communications I consent to receiving, by telephone call, text message, or voicemail transmission, instructions and other healthcare communications by or on behalf of the practice at the email/telephone number or text address I have provided in my patient record. The instructions may include, but are not limited to: pre-procedure instructions, educational information and prescription information. Other communications may include, but are not limited to, healthcare communications to family or designated representatives regarding treatment or condition, reminder messages regarding appointments, insurance or billing or requests for feedback about my visit and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system. If you do not wish to be contacted via text message, please inform the office.

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)\_\_\_\_\_

Signature of Patient (Parent or Guardian if minor)

\_\_\_\_\_

Signature

\_\_\_\_\_

Date