

**ADVANCE ORAL AND MAXILLOFACIAL SURGERY**

**STEVEN A. SAXE D.M.D.**

**1570 S. Rainbow Blvd.**

**Las Vegas, NV 89146-2956**

**(702) 258-0085 Fax (702) 258-0585**

**\*\*PATIENT INFORMATION\*\***

PATIENT'S NAME \_\_\_\_\_ (MISS-MS.-MRS.-MR.)  
Last First MI

Patient's Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widowed

AGE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ lbs. HEIGHT: \_\_\_\_\_ ft. \_\_\_\_\_ in. SEX: Male or Female

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ EMPLOYER: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ BUS PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE ( ) \_\_\_\_\_ - \_\_\_\_\_

**\*\*INSURED'S INFORMATION OR SELF -PAY RESPONSIBLE PARTY'S INFORMATION\*\***

SAME AS ABOVE OR INSURED'S NAME: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

RELATIONSHIP W/PATIENT \_\_\_\_\_ ADDRESS: \_\_\_\_\_

SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ EMPLOYER WHERE INSURANCE WAS ISSUED: \_\_\_\_\_

**\*\*EMERGENCY CONTACT\*\***

NAME OF NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**\*\*MEDICAL/DENTAL INFORMATION\*\***

REFERRING DOCTOR OR DENTIST: \_\_\_\_\_ DID YOU BRING X-RAYS: YES Or NO

PRIMARY DENTIST: \_\_\_\_\_ PHONE NUMBER: ( ) \_\_\_\_\_ - \_\_\_\_\_

MEDICAL DOCTOR: \_\_\_\_\_ PHONE NUMBER: ( ) \_\_\_\_\_ - \_\_\_\_\_

**\*\*INSURANCE INFORMATION\*\***

PRIMARY DENTAL BENEFITS: \_\_\_\_\_

GROUP#: \_\_\_\_\_ MEMBER#/ID#/POLICY#: \_\_\_\_\_

SECONDARY DENTAL BENEFITS: \_\_\_\_\_

GROUP#: \_\_\_\_\_ MEMBER#/ID#/POLICY#: \_\_\_\_\_

PRIMARY MEDICAL INSURANCE: \_\_\_\_\_

GROUP#: \_\_\_\_\_ MEMBER#/ID#/POLICY#: \_\_\_\_\_

SECONDARY MEDICAL INSURANCE: \_\_\_\_\_

GROUP#: \_\_\_\_\_ MEMBER#/ID#/POLICY#: \_\_\_\_\_

**PLEASE READ:** I agree to pay for all services rendered at the time of service. I authorize the release of any information relating to my insurance claims and authorize insurance payment directly to Dr. Steven A. Saxe for services provided. I agree to be responsible for all fees, regardless of insurance coverage, which must be paid within 30 days. Any misinformation I provide on this form will lead to immediate payment upon discovery for all services rendered. If, for any reason, I default on my account, I agree to pay for all collection fees, attorney fees, court cost, filing fees, forwarding fee, and recovery costs involved in the collection of the overdue balance of my account. I understand that I will be charged \$50.00 for any appointment that I fail or if I do not give the office a 24 hour notice. All returned checks will be charged at \$30.00. A \$20.00 administrative fee will be applied when multiple insurance companies require billing by this office. A 10% compounded interest fee will be added per month to each account for unpaid balances. A 3% convenience fee will be charged for co-pays not paid with cash or debit card. **ORIGINAL DIAGNOSTIC FILMS ARE THE PROPERTY OF THIS OFFICE.** The fee paid for x-rays and radiographs is for analysis only. Copies of films are available at a fee of \$15.00. A \$20.00 fee will be accessed for the filling out of any forms or writing letters by the doctor.

SIGNATURE OF THE PATIENT \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF OTHER: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**PATIENT DISCLOSURE INSTRUCTIONS**  
**Advance Oral & Maxillofacial Surgery**  
**Dr. Steven A. Saxe D.M.D.**

*I wish to be contacted in the following manner (check all that apply):*

\_\_\_ Home Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
\_ O.K. to leave message with detailed information  
\_ Leave message with call-back Number only

\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
\_ O.K. to leave message with detailed information  
\_ Leave message with call-back Number only

\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
\_ O.K. to leave message with detailed information  
\_ Leave message with call-back Number only

\_\_\_ Written Communication  
\_ O.K. to mail to my home address  
\_ O.K. to mail to my work/office address  
\_ O.K. to fax to number indicated

\_\_\_ Email: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_

I allow you to give my clinical information to or answer question from (circle all that apply):

Spouse: \_\_\_\_\_  
Parent: \_\_\_\_\_  
Child: \_\_\_\_\_  
Doctor/Dentist: \_\_\_\_\_  
Other (please specify): \_\_\_\_\_  
None

X \_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Birth Date



- 40. yes no Have you had orthodontic care (Braces on your teeth) ?
- 41. yes no Have you ever had psychiatric care?
- 42. yes no Have you or any family members ever had a problem with being put to sleep or general anesthesia?
- 43. yes no Do you smoke or use tobacco in any form? Or date that you Quit \_\_\_/\_\_\_/\_\_\_  
What? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_
- 44. yes no Have you used heroin, cocaine, marijuana or other such drugs?
- 45. yes no Do you drink alcoholic beverages?  
What? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_
- 46. yes no Do you wear contact lenses?
- 47. yes no Have you had anything to eat or drink in the last 8 hours?

**ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS? (Please List Medications OR list on a separate paper)**

- a. yes no Biophosphates, Osteoporosis drugs (i.e. Fosamax, Boniva, etc.)
- b. yes no Diet pills (Phen, Redux)
- c. yes no Antibiotics or sulfa drugs
- d. yes no Anticoagulants (blood thinners)
- e. yes no High blood pressure medicine
- f. yes no Steroids (Cortisone, Prednisone)
- g. yes no Antihistamines and/or Cold Medicine
- h. yes no Aspirin
- i. yes no Insulin (medicine for diabetes)
- j. yes no Digitalis or drugs for heart problems
- k. yes no Nitroglycerine (medicine for chest pain)
- l. yes no Dilantin (medicine for seizures)
- m. yes no Psychiatric Medications
- n. yes no Herbal or Home Remedies
- o. yes no Pain Medicine (Advil/Ibuprofen, Tylenol or Prescription)
- p. yes no Other or over the counter \_\_\_\_\_

**ANY HISTORY OF ALLERGY TO OR UNUSUAL REACTION TO?**

- a. yes no Local anesthetics (dental injections, spinal anesthesia)
- b. yes no Penicillin, Amoxicillin, Keflex, Clindamycin, or other antibiotics \_\_\_\_\_
- c. yes no Codeine
- d. yes no Barbiturates, sedatives or sleeping pills
- e. yes no Aspirin
- f. yes no Iodine
- g. yes no Eggs
- h. yes no Other \_\_\_\_\_

**WOMEN**

- 1. yes no Are you or do you think you may be pregnant?
- 2. Last known menstrual period? \_\_\_/\_\_\_/\_\_\_
- 3. yes no Are you nursing a baby?
- 4. yes no Are you taking birth control pills?
- 5. yes no Do you require a consultation regarding a possible pregnancy or missed menstrual cycle?

**HAVE YOU EVER BEEN A PATIENT IN A HOSPITAL, SURGERY CENTER OR HAD ANY SURGICAL PROCEDURES?**

**NONE**

- Reason: \_\_\_\_\_ Date: \_\_\_\_\_
- Reason: \_\_\_\_\_ Date: \_\_\_\_\_
- Reason: \_\_\_\_\_ Date: \_\_\_\_\_
- Reason: \_\_\_\_\_ Date: \_\_\_\_\_

**I CERTIFY THAT ALL STATEMENTS HEREIN ARE TRUE AND CORRECT ABOUT MYSELF OR THE PATIENT. I CAN READ AND COMPREHEND THE ENGLISH LANGUAGE.**

\_\_\_\_\_  
SIGNATURE OF PATIENT (IF NOT A MINOR)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN/OTHER (if patient is minor)

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**Advance Oral and Maxillofacial Surgery**  
Diplomat of the American Board of Oral and Maxillofacial Surgery

***Dr. Steven A. Saxe, D.M.D.***

1570 S. Rainbow Blvd.  
Las Vegas, Nevada 89146  
Tel: (702) 258-0085  
Fax: (702) 258-0585  
[NVJAWDOC@AOL.COM](mailto:NVJAWDOC@AOL.COM)

I, \_\_\_\_\_, hereby give permission to Dr. Steven A. Saxe, D.M.D. to file a formal written complaint on my behalf to my insurance company \_\_\_\_\_ and the insurance commissioner if my insurance company fails to comply with the Nevada State Law NRS 689A.410 and NRS 689B.255 by NOT paying my claim(s) within 30 days of submission.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

No Insurance

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);  
Obtaining payment from third party payers (e.g. my insurance company);  
The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed Month: \_\_\_\_\_ Day: \_\_\_\_\_, 20\_\_\_\_.

Print Patient Name: \_\_\_\_\_

Relationship to Patient: self    mother    father    other: \_\_\_\_\_

Signature: X \_\_\_\_\_