Form Instructions

1. Use the tab key to move from form field to form field.

2. To enter text, tab to (or click) the area you would like to type in and begin typing.

3. Some form fields require a choice to be selected. Click in the boxed or underlined area and a check mark will appear.

4. To save the form and complete at a later time, click the disc button in the adobe reader tool bar at the top left of the page.

5. To print a copy of the form for your records, click the “Print Form” button at the bottom of the last page.

6. To send the completed form to our office, click the “Submit Form” button at the bottom of the last page.

If you experience difficulty submitting this form, please follow the instruction below:

1.Print the form

2. Complete the form with a pen and bring the form to the office at the time of your appointment.

3. If you do not have a printer, you may fill out the form at our office prior to your appointment. Please allow an extra fifteen minutes before your scheduled appointment. Please call our office if you have any questions.

For your protection:

This form is hosted on a secure server and may only be viewed by our office. You may feel confident in filling out this form, as all of your information will be kept safe and confidential during the process.

Get Acquainted Questionnaire

Gerald W. Bird, D.M.D   Board Certified in Oral and Maxillofacial Surgery   Jay A. Johnson D.M.D.

Patient Information Please Print   **Today's Date: / /**

Title: Mr. Mrs. Miss Ms. Mstr. Dr. Fr. Sr.

Social Security Number:______________________

Name: ____________________________________
Last, First Middle Initial

Street Address: ______________________________

City: _____________________State: ____________

Zip: __________ Telephone: ___________________

Daytime Telephone: __________________________

Date of Birth: ________/_________/_____________

Marital Status: Single Married Divorced Widowed

Spouse: ____________________________________

Occupation: ________________________________

Employer: _________________________________

Address: ___________________________________

City: _______________State: __________________

Zip: _________Telephone: ____________________

Student Status: Full-Time [ ] Part-Time [ ]

School Name: _______________________________

Emergency Contact: __________________________

Relationship: ___________ Telephone: ___________

Person Responsible for Payment If Not The Person Listed Above (Parent When Applicable)

Name: _____________________________________

Relationship To Patient: _______________________

Street Address: ______________________________

City: __________________State: _______________

Zip: __________Telephone: ____________________

Social Security Number: ______________________

Employer: ___________________________________

Address: ____________________________________

City: _________________ State: _______________

Zip: __________Telephone: ____________________

Referral Information Whom May We Thank For Referring You? ______________________

Name of Dentist: _____________________________

City: _____________Date of Last Visit: ___________

Other Dental Specialist(s): ______________________
(i.e. Orthodontist, Periodontist)

Did you bring x-rays with you? Yes [ ] No [ ]

Name of Physician: ___________________________

City: __________Date of Last Visit: _____________

Insurance Information Do You Desire To File A Claim? Yes [ ] No [ ] Dental [ ] Medical [ ] Both [ ]

Name of Insured: _____________________________

Relationship to Patient: _________________________

Social Security Number: _________________________

Insured's Date Of Birth: _________________________

Dental Insurance Agency: ______________________

Address: ____________________________________

Medical Insurance Company: ___________________

Address: ____________________________________

Health History Record

Your health is important to us. In order to provide excellent care with safety, it is necessary to become acquainted with vital information related to each patient. Thus it is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask the Doctor or a member of the staff for assistance.

Allergies

Penicillin_______________**Codeine**________________
Aspirin_________________**Other**_________________
None Known____________________________________

Present complaint or problem and its duration ______________________
____
____

Age:__________ Weight:___________ Height:_____________

Question	Yes	No	?
1. Are you now in good health?			
2. Are you now, or have you been under the care of a physician during the past 2 years?			

If so, for what condition?____

3. Date of last physical examination:______________________________________

Question	Yes	No	?
4. Have you ever been a patient in a hospital?			

Reason: ______________________ Date: ____________
Reason: ______________________ Date: ____________
Reason: ______________________ Date: ____________
Reason: ______________________ Date: ____________

5. Please list all medications you are currently taking or have taken in the last year. If none, write none

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

Question	Yes	No	?
A. Have you ever taken "Blood Thinners" or Steroid (Cortisone) Therapy?			
B. Are you sensitive or allergic to penicillin or any other drugs, medicines or anesthetics?			

C. If so, Please list:____

6. Do you have, or have you ever had?: (Check all that Apply)

a) heart trouble
b) high or low blood pressure
c) hear murmur
d) stroke
e) rheumatic fever
f) angina pectoris
g) chest pain
h) swollen ankles
I) shortness of breath
j) emphysema
k) persistent cough
l) asthma/bronchitis
m) blood disorder/bleeding problems
n) anemia
o) porphyria
p) kidney, liver or lung disease
q) hepatitis / jaundice
r) severe headaches
s) sinus trouble
t) nosebleeds (frequent)
u) epliepsy
V) stomach (ulcer, etc.)/ bowel problems
w) hyprethyroidism / hypothyrodism (thyroid trouble)
x) glaucoma
y) cancer
z) diabetes
aa) veneral disease
bb) drug addiction
cc) alcoholism
dd) tuberculosis
ee) arthritis
ff) scarlet fever
gg) allergies
hh) others (please indicate)

Question	Yes	No	?
7. Are you subject to any nervous disorders, fainting or dizziness?			
8. Are you subject to excessive bleeding?			
9. Have you ever had psychiatric treatment?			
10. Do you have any difficulty in opening your mouth wide? Jaws ever click or catch?			
11. Have you ever had any Orthodontic care?			
12. Have you ever had any injury to your face or jaws?			
13. Have you ever had any difficulty with past dental treatment? Explain:____________			
14. Have you ever had a local anesthetic (numbing an area)?			
15. Have you ever had any difficulty with the use of a local anesthetic ("Novocain")?			
16. Have you ever had a general anesthetic (completely asleep)?			
17. Have you or any family member experienced any problem associated with a general anesthetic or "Twilight Sleep"? Explain:____________			
18. Do you have any numbness or tingling sensation in any part of your body?			
19. Have you ever received radiation or surgical treatment for a tumor, growth or condition about your head, mouth, lips?			

20. Females: Are you pregnant?___________How many months?_____________ Are you nursing a baby?________________________
21. Do you use tobacco or smoke?_________________How much?_________________How long?_____________________________

Question	Yes	No	?
22. Do you wear contact lenses?			
23. Have you had anything to eat or drink in the last 6 hours?			

24. Is there any information, not given about, that you think is important for proper health care treatment in your case? ____
____

The above medical history is accurate and current to the best of my knowledge.

Signature: ______________________________ Date: ____________

Financial Acknowledgement and Agreement

We are pleased that you have selected our office for your oral surgery care. Our practice has grown as a result of the quality patient care we provide as well as our excellent relationship with our referring doctors and patients. We have developed this form so that you fully understand your financial responsibility for your oral surgery care.

Our ultimate goal is to provide the finest in oral surgery care for you or your family member. Our responsibility is to you, our patient, and our referring doctors. In an effort to preserve the best relationship with our patients, we have opted to be a contracted *medical* provider only with a limited number of insurance carriers. They are: Medicare, Private Health Care Systems (PHCS) and Humana Choice Care.

Our staff of business professionals will be happy to file an insurance claim for your oral surgery services to your *primary insurance carrier*. The benefit paid by your insurance carrier for these services may be less than the actual charge and is a direct result of the plan selected by your employer.

The care we provide is directly to our patient; therefore, the patient or their parent/guardian is fully responsible for all procedural fees in our office. Payment is due at the time service is rendered. Payment may be made by: cash, local check (with ID), money order, MasterCard, Visa, Discover, and American Express. Financing through Care Credit may be an option for patients who desire a monthly payment plan. This option is available to pre-qualified applicants (pre-qualified prior to their appointment date) for surgical fees in excess of $300.

I have fully read and understand the Financial Acknowledgement and Agreement. I understand and agree with my financial responsibilities for oral surgery care rendered by Gerald W. Bird, D.M.D., P.A. and Jay A. Johnson, D.M.D.

____________________________ ____________________________

Patient Name Patient/Legal Guardian Signature *(18 years or older)*

____

Date

<u>Insurance Waiver</u>

Thank you for providing Gerald W. Bird, D.M.D., P.A. and Jay A. Johnson, D.M.D. with your complete and correct insurance information. This notice is to inform you of your obligation to our practice regarding the filing of your insurance claim. We will be happy to file an insurance claim to your *primary insurance carrier* as a courtesy to you. By filing your claim, we are in no way releasing you of your financial obligations and responsibilities.

For patients with insurance carriers that make payment to our office, our office may call for an *<u>estimate</u>* of insurance coverage for procedures in excess of $300. This is done when your surgery is scheduled on a different day from your consultation. In qualified cases, a down payment will be due. Down payments are unique for each surgical case and are not reflective of your co-payment or deductible only. In cases where your insurance carrier does not make payment to our office or benefits are limited, full payment will be due on the day of surgery. In all cases, the patient or their guardian are responsible for all fees charged by our office.

Once payment is received by your primary insurance carrier, we will determine the amount remaining. If there is a balance remaining, we will bill you with 30 day terms. If there is a credit balance, we will send a refund to the patient (usually within one week). Payment from your insurance carrier is expected within 45 days. If payment is not received within this reasonable time period, we will bill you for the balance remaining with 30 day terms. Please understand that no insurance carrier will guarantee payment of benefits; therefore, our office can offer no guarantee as to the amount you may owe.

I have read, understand and agree with all terms and conditions included within this insurance waiver.

______________________ Patient Name	______________________ Patient/Legal Guardian Signature *(18 years or older)*
______________________ Date	
______________________ Insured Member's Full Name	______________________ Insurance ID#
______________________ Insured's Date of Birth	______________________ Employer Name & Address
______________________ Primary Dental Carrier	______________________ Claims Address & Phone#
______________________ Primary Medical Carrier	______________________ Claims Address & Phone#

Notice of Privacy Practices for Protected Health Information

Drs. Gerald W. Bird & Jay A Johnson
Oral and Maxillofacial Surgery
96 Willard Street, Suite 105
Cocoa, FL 32922-8008
(321) 631-7000

Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for:

____this___________day of___________,200____.
(day of week) (date) (month) (year)

A copy of this signed, dated Acknowledgement shall be effective as the original.

____
PLEASE PRINT YOUR NAME

____
PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer

Office Use Only As privacy officer, or their representative, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

________ It was emergency treatment.
________ I could not communicate with the patient.
________ The patient refused to sign.
________ The patient was unable to sign because: ____________________________________
________ Other (please describe) ____

Signature of privacy officer ____