semmel oral + facial surgery

PATIENT REGISTRATION FORM

*Please ***do not forget*** to sign the bottom of pages **1, 3, and 4.** Thank you! *

Name: First_____ MI_____ Last_____ Preferred Name:_____

Sex: M/F **Race:** _____**Date of Birth**: Month _____ Day _____ Year _____ **SSN/ID#:**___

Address: Street _____Apt:_____ City _____State ____ Zip _____

Phone Numbers: Primary _____ Secondary _____

Email Address: _____ **Primary Medical Doctor:** _____

Emergency Contact: _____ **Emergency Contact Phone Number:** _____

General Dentist: _____ **Other Dental Specialist:** _____

Pharmacy: _____ **Pharmacy Location:** _____

Financial Information

Initial _____Dr. Semmel is not a network provider for any medical or dental insurance program (including Medicare and Medicaid). Therefore, we collect payment in full at the time of service. We accept cash, personal checks, Visa, Mastercard, Discover, American Express or debit cards.

Initial _____Dr. Semmel has opted out of the Medicare program. Medicare ***will NOT pay*** for any medical procedures performed by Dr. Semmel. Therefore, Medicare WILL NOT accept any claims from Dr. Semmel or the patient.

Initial _____As a courtesy to our insured patients, we will file the claim, along with required documentation to your insurance using the information you provide.

Initial _____You, the patient, are responsible for providing all insurance information. Please provide us with correct spellings, correct dates of birth, and updated demographic information. This includes new ID numbers, as well as subscriber information. When providing dental insurance please provide Insurance carrier, and correct claims address. Our office will generate a claim with the information you provide. The claim form indicates that insurance reimburse policy holder directly.

Initial _____Upon scheduling dental implant surgery, we will collect half of surgical fees as a deposit. The remaining balance will be collected upon check-in the day of surgery.

Insurance Details and Subscriber Information

Name: First_____ MI_____ Last_____ **Phone #**: _____

Relationship to patient: (please check one): ( )Self ( )Parent ( )Guardian ( )Spouse ( ) Other _____

Address: Street _____ City _____State ____ Zip _____

DOB: _____ **SSN:** _____ **Insurance Company Name:** _____

Claims address: _____ Payor **ID**: _____

Subscriber ID: _____ **Group Number:** _____

** _____ _____ _____

Patient or Authorized Attendant's Signature **Relationship to Patient** **Date**

semmel oral + facial surgery

MEDICAL HISTORY FORM

Please be honest and accurate to the best of your ability

Height: _____ Weight: _____

Were you given any antibiotics or pain medicine for this appointment **CIRCLE ONE** *YES or NO*

Do you have or have you had the following diseases or problems? **CIRCLE ALL THAT APPLY AND EXPLAIN**

Heart Disease: Heart Attack, Chest Pain, Coronary Artery Disease, Heart Surgery, Pacemaker, Defect at Birth, Valve Replacement, Irregular Heartbeat, Congestive Heart Failure, History of Bacterial Endocarditis, Other

_____

Breathing Problems: Asthma, Bronchitis, COPD, Emphysema, Sleep Apnea, Shortness of Breath, Tuberculosis, Other

Do you use C-PAP or BI-PAP? _____

Vascular: High Blood Pressure, Low Blood Pressure, Stroke, TIA, Hardening of the Arteries, Valve Replacement, Other

_____

Endocrine: Diabetes (Insulin Dependent or Non-Insulin Dependent), Hypoglycemia, Thyroid problems, Other

Do you use Mounjaro, Ozempic, Wegovy or Saxenda? _____

Neurologic: Anxiety, Dementia, Epilepsy, Fainting Spells, Headaches, Seizures, Mentally Handicapped, Other

_____

Liver/Kidney Disease: Hepatitis, Jaundice, Dialysis, Kidney Failure, Kidney Stones, Other

_____

Musculoskeletal: Arthritis, Artificial Joint, Fibromyalgia, MS, Osteoporosis, Other

_____

Gastrointestinal: Ulcers, GERD, Colitis, Crohn's Disease, Other

_____

Head and Neck: Chronic Sinusitis, Swollen Glands, Difficulty Swallowing, Glaucoma, Radiation Therapy, TMJ Disorder

_____

Hematologic: Anemia, Bleeding Disorder, Blood Transfusions, Hemophilia, Leukemia, Lymphoma, Other

_____

Cancer: Breast, Prostate, Lung, Mouth, Colon, Skin, Uterine, Other Cancer, Chemotherapy, Radiation

_____

Immune System: HIV, AIDS, Immunosuppressive Drug Therapy (Remicade, Enbrel, Humira), Other

_____

Continued next page…

Weight Management: Gastric Bypass, Mounjaro, Ozempic, Wegovy, Saxenda, Other

_____

Females: Pregnant, Breast Feeding, other _____

***Do you to take a "PREMED" antibiotic prior to dental treatment by a medical provider (ex: Cardiologist, Orthopedist)?** **CIRCLE ONE** *YES or NO* ***If yes, which antibiotic, and why?**_____

***Have you taken the following Bisphosphonate Drugs?** Fosamax, Actonel, Boniva, Reclast, **Zometa, Aredia**

***Do you use tobacco products?** **CIRCLE ONE** *YES or NO* **If yes, what products and how often?** _____

***Alcohol use:** **CHECK ONE** ____ None ____Social or Occasional ____Daily

***Do you have a history of Drug Abuse?** **CIRCLE ONE** *YES or NO* **Please explain:** _____

***Are you currently under a Pain Management Contract?** **CIRCLE ONE** *YES or NO*

If yes, please list your doctor: _____

***Please list ALL previous SURGERIES you have had with SEDATION (ex: colonoscopy, wisdom teeth, dental implants) and approximate dates:**

_____

_____

_____

***Did you or any family members have complications following previous surgeries?** **CIRCLE ONE** *YES or NO*

Please explain: _____

***Did you have Nausea or Vomiting following previous surgeries?** **CIRCLE ONE** *YES or NO*

***Are you allergic to any of the following?** **(Please check all that apply)**

__ Amoxicillin	__ Eggs	__ Sulfa Medicines
__ Anesthetics	__ Latex	__ Sulfites
__ Aspirin	__Penicillin	__Soy
__Codeine	__ Narcotic	__Other _____

***Please list all current MEDICATIONS, HERBAL and/or VITAMINS that you are taking:**

_____

_____

_____

_____

** _____ _____ _____

Patient or Authorized Attendant's Signature Relationship to Patient Date

Doctor Signature: _____ Date: _____

HIPAA RECEIPT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you (the patient) are having a procedure under sedation, by signing this form you (the patient) will automatically give permission to Semmel Oral & Facial Surgery to disclose personal medical information to your driver/escort on the day of the procedure even if the person is not listed by name on this form.

I authorize *Semmel Oral & Facial Surgery* to disclose personal medical information to the following people:

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

☐ **Yes** ☐ **No** **I authorize *Semmel Oral + Facial Surgery* to leave voicemails about *appointment related* information**

☐ **Yes** ☐ **No** **I authorize *Semmel Oral + Facial Surgery* to leave voicemails about *clinical related* information**

** _____ _____ _____

Patient or Authorized Attendant's Signature **Relationship to Patient** **Date**