RIVERBEND
ORAL SURGERY

Kristen Kilgore, DDS
Board Certified Oral and Maxillofacial Surgeon

WELCOME TO OUR PRACTICE!!

Patient Information: **Today's Date:_____**

❑ Mr. ❑ Mrs. ❑ Ms. First Name:_____ M:_____ Last Name:_____ Nickname:_____

Sex: ❑ Male ❑ Female Birth Date:_____ Age:_____ Soc. Sec. #_____ E-mail:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Tel.(____)_____ Cell.(_____)_____ Alternate:(_____)_____

Referred By:_____ Dentist:_____ Medical Doctor:_____

Driver's Lic #:_____ State:_____

Are you a student?_____Full-Time or Part Time?_____ Name of School:_____

Responsible Party / Guarantor Information (If under 18 years old):

First Name:_____ M:_____ Last Name:_____ Birth Date:_____ SS#:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Tel.(____)_____Cell.(_____)_____ Alternate:(_____)_____

Insurance Information:

Primary Dental Insurance		Primary Medical Insurance	
Insurance Co. Name:		Insurance Co. Name:	
Claims Address:		Claims Address:	
Phone #:		Phone #:	
Policy #:	Group#:	Policy #:	Group#:
Policy Holder:	Relation to pt:	Policy Holder:	Relation to pt:
Home Address:		Home Address:	
SS #:	Date of Birth:	SS #:	Date of Birth:
Employer:	Home Phone:	Employer:	Home Phone:

I certify that I have read and I understand the questions above. I will not hold my surgeon or any member of his / her staff responsible for any errors or omissions that I have made in completing this form.

Patient/Guardian:_____ Date:_____

Print Name:_____

Patient Name (Print): _____ Height:_____ Weight:_____

Have you had or do you currently have:

Heart Condition (Irregular heartbeat, heart valve issue, previous heart surgery, etc): Yes / No	Please Describe:
Have you had any major illness or been hospitalized in the past 5 years : Yes / No	Please Describe:
History of Stroke and/or Heart Attack: Yes / No	
High Blood Pressure: Yes / No	
Lung / Breathing Condition (Asthma, COPD, etc): Yes / No	Please Describe:
Tuberculosis: Yes / No	
Blood or Bleeding Disorder: Yes / No	Please Describe:
Taking Blood Thinners: Yes / No	
Hepatitis, Jaundice, Liver disease: Yes / No	
Convulsions / Epilepsy: Yes / No	
Thyroid Trouble: Yes / No	
Diabetes: Yes / No	Last HbA1c: Date:
Kidney Condition: Yes / No	Please Describe:
Bone Condition: Yes / No	Please Describe:
Infectious/Contagious Diseases (HIV, Hep C): Yes / No	Please Describe:
Cancer / Radiation Treatment: Yes / No	Please Describe:
Reaction to anesthesia or sedation in the past: Yes / No	
Previous surgeries: Yes / No	Please list (with DATE):
Tobacco Use: Yes / No	Please Describe:
Alcohol Use: Yes / No	If so, how many drinks per week:
Illicit Drug Use (marijuana, cocaine, etc): Yes / No	If so, which one: _____ _____. How many times per week:

Allergies / Medications

Please list any **ALLERGIES** (including drugs, seasonal, food)	Please list all of you current **MEDICATIONS** including herbal supplements (***with DOSAGES and FREQUENCY that you take them***):

I certify that I have read and I understand the questions above. I will not hold my surgeon or any member of his / her staff responsible for any errors or omissions that I have made in completing this form.

Patient/Guardian Signature:_____ Date:_____ Dr. Initials:_____

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OFFICE FINANCIAL POLICY

Insurance eligibility and benefits will be verified at the time of your visit.

We do not accept any HMO/DMO plans.

You will be responsible for any services not covered by your plan.

Your treatment plan will be discussed following your consultation. We will discuss deposits due and financial arrangements. If all or part of your treatment is not covered by your plan the non covered portion is due in full prior to your treatment date.

At your request we will file a pre-determination of benefits to your insurance company. Please allow 2-6 weeks for a reply. ***Please note that pre-determinations are only ESTIMATES and no guarantee of payment can be made by Riverbend Oral Surgery or your insurance company.***

If a pre-determination is not received prior to your requested surgery date, your estimated deposit will be required at the time of service.

Some insurance companies that we are not in contract with will reimburse the patient directly. In these cases, we will collect payment in full at the time of service and will file your claim on your behalf as a courtesy.

As a courtesy Riverbend Oral Surgery will file all claims to your insurance on your behalf. It is your responsibility to follow up with your insurance company regarding payments not received within 60 days.

Payment is due within 60 days of the date of service. You will receive monthly statements as a reminder to follow up with your insurance company.

IMPORTANT: If you are 18 years of age or older at the time of your appointment or treatment THE PATIENT will be the financially responsible party REGARDLESS OF INSURANCE OR PAYMENT METHOD. Any refunds due will be issued directly to the patient to the address on the patient information paperwork. If you are 18 years (or older) and your account is delinquent, THE PATIENT will be sent to our Collection Agency.

I have read and understand the terms of this policy:

_____ _____

Patient / Guarantor Date

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sur Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) 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

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Pharmacy Information

Prescriptions are sent electronically to your pharmacy. We will need the correct pharmacy information in order to do this for you.

If pharmacy information is unknown or details are not provided, prescriptions will be sent to the HARRIS TEETER Pharmacy at 4701 Smith Farm Road, Charlotte, NC 28216 (Next door) (704) 949-2220

Please provide the following:

Name of Pharmacy:_____

Address (**WITH ZIP CODE PLEASE!**):_____

Pharmacy Phone Number (Required):_____

I attest the above information is correct to the best of my knowledge.

Patient Signature:_____

Patient Name (please print):_____