



Drs. Scheetz & Rekos
Oral & Facial Surgeons of Ohio
THE CENTER FOR DENTAL IMPLANTS

PATIENT REGISTRATION

Please complete this form in its entirety.

Mr. Mrs. Miss Dr.

Patient Name _____
Last First Middle Maiden

Preferred Name (if any) _____ Date of Birth _____ Age _____

Male Female Patient SSN _____

Marital Status Single Married Divorced Partnered Widowed

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

What is your preferred method of contact? Home Phone Work Phone Cell Phone

May we leave messages regarding appointment reminders? Yes No

Emergency Contact Person _____ Phone _____

Patient Employer _____ Employer Phone _____

Are you a student? Yes No School Name: _____ Full Time Part Time

General Dentist _____
Name Phone

Orthodontist _____
Name Phone

Family Physician _____
Name Phone

Pharmacy _____
Name Phone

Have you or a family member ever been a patient of our practice? Yes No

If yes, name of patient (s) _____

Whom may we thank for referring you to our office?

Dentist Orthodontist Internet/Website Family/Friend Other _____

Patient Signature (Parent signature if patient is minor): _____ Date: _____



Thank you for choosing Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) for your oral & maxillofacial surgery needs. We are committed to providing the services you expect in a safe, friendly, and professional manner.

Patients who do not have medical or dental insurance

Payment is expected in full prior to the services being rendered.

Patients who have verified medical and/or dental insurance benefits

Deposit or full payment (in some cases) is payable prior to the services being rendered. As a courtesy to you, we will file insurance. Any credit due you will be refunded or applied to future services. A predetermination of benefits will be submitted ONLY at your request.

Payment Options

- Cash, check, MasterCard, Visa, Discover, American Express or debit cards are acceptable.
- H.S.A. and Flexible Spending benefit cards or checks are acceptable.
- Care Credit is available for those patients who prefer to extend payments beyond the conclusion of treatment. We are pleased to offer Care Credit; the American Dental Association approved commercial line of credit specifically designed for the payment of dental care. To learn more about this option, feel free to speak to the financial office.

*****PLEASE NOTE** Financing options are not available in conjunction with the courtesy discount and/or In-network dental plans.***

Account Refunds

Accounts reflecting a credit balance after insurance payment is received, change of treatment plan, etc. will be refunded via check.

If you arrive on the day of your appointment with no means of payment, we reserve the right to reschedule your appointment.

Please note the following:

- Any quoted fees are an estimate only and are valid for a period of one year.
- The financial obligation for services received is your responsibility and not the responsibility of Oral & Facial Surgeons of Ohio or your insurance carrier.
- Divorced Parents: The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.
- We will file your primary medical and primary dental insurance. We will file to secondary dental insurance should a balance remain on the account after primary payment is received. Filing of secondary medical insurance claims are the patient's responsibility.
- Account balance is due 60 days from the date the services were rendered whether payment has been received from your insurance carrier or not.
- A 1.5% service charge (18% per annum) may apply to past due balances.
- In the event your account becomes delinquent, you may be responsible for any and/or all collection fees (i.e. 35% of account balance sent to collection agency).



FINANCIAL RESPONSIBILITY

Patient is responsible party *(if you check this box, move on to the signature line below)*

Responsible Party Information

(Parent, Legal Guardian or person that will pay for services rendered)

Name (First) _____ (Last) _____ (MI) _____

Relationship Spouse Parent Other _____

Date of Birth _____ SSN _____

Address (Street) _____ (City) _____ (State) _____ (Zip) _____

Home Phone () _____ Cell Phone () _____

Employer _____ Employer Phone () _____

By signing below I verify that I have read, understand and accept the guidelines and terms stated within in the OFSO Financial Policy and that I am the financially responsible party for this patient account.

 Signature of Responsible Party

 Print Name

****PLEASE NOTE****

Divorced Parents: The parent who is present with the patient at time of appointment will be considered the "financially responsible party" and will be accountable for all fees incurred.



Please complete **all** sections of this form. As a courtesy, we are happy to file insurance claims on your behalf. If this form is not completed in its entirety, we will be unable to file claims. Please have your insurance cards(s) available for our staff to scan into our system. **Please note we will file primary dental, secondary dental and primary medical claims, but we will not file with secondary medical, Medicare, Medicaid or Care Source.**

Primary Dental Insurance

**the subscriber is the holder of the insurance policy*

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber DOB	
P.O. Box City St Zip		Subscriber S.S. #	
Employer Name		Identification #	
Tel. #		Group #	

Relationship to patient: Self Spouse Parent Other _____

Marital Status: Single Married Divorced Widowed **Subscriber Sex:** Male Female

Is subscriber address the same as patient address? Yes No

If no, address: _____

Primary Medical Insurance

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber DOB	
P.O. Box City, St Zip		Subscriber S.S. #	
Employer Name		Identification #	
Tel. #		Group #	

Relationship to patient: Self Spouse Parent Other _____

Marital Status: Single Married Divorced Widowed **Subscriber Sex:** Male Female

Is subscriber address the same as patient address? Yes No

If no, address: _____

Secondary Dental Insurance ****Please Note: We do not file secondary medical claims but we will give you information in order for you to file.****

Insurance Co. Name		Subscriber Name	
Insurance Tel. #		Subscriber DOB	
P.O. Box City ST Zip		Subscriber S.S. #	
Employer Name		Identification #	
Tel. #		Group #	

Relationship to patient: Self Spouse Parent Other _____

Marital Status: Single Married Divorced Widowed **Subscriber Sex:** Male Female

Is subscriber address the same as patient address? Yes No

If no, address: _____



HEALTH HISTORY

The scope of oral & maxillofacial surgery includes the diagnosis and treatment of disease, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Health problems may affect the outcome of treatment. ***Note*** *Your answers are for our records only and will be considered confidential.*

Are you currently in good health? Yes No Have you had any change in your health in the last year? Yes No

Height _____ Weight _____ Do you take antibiotics prior to dental treatment? Yes No

	Y	N	Date		Y	N	Date
Heart Pacemaker.....	<input type="radio"/>	<input type="radio"/>	_____	Hip, Knee or any joint prosthesis.....	<input type="radio"/>	<input type="radio"/>	_____
Heart Trouble.....	<input type="radio"/>	<input type="radio"/>	_____	Stomach Ulcers.....	<input type="radio"/>	<input type="radio"/>	_____
Heart Murmur.....	<input type="radio"/>	<input type="radio"/>	_____	Jaundice, Hepatitis, Liver Disease....	<input type="radio"/>	<input type="radio"/>	_____
Heart Attack.....	<input type="radio"/>	<input type="radio"/>	_____	Arthritis.....	<input type="radio"/>	<input type="radio"/>	_____
Chest Pain (Angina).....	<input type="radio"/>	<input type="radio"/>	_____	Back injury, pain, surgery.....	<input type="radio"/>	<input type="radio"/>	_____
Mitral Valve Prolapse.....	<input type="radio"/>	<input type="radio"/>	_____	Pain in Jaw Joints.....	<input type="radio"/>	<input type="radio"/>	_____
Heart Valve Replacement.....	<input type="radio"/>	<input type="radio"/>	_____	Stroke.....	<input type="radio"/>	<input type="radio"/>	_____
Rheumatic Fever.....	<input type="radio"/>	<input type="radio"/>	_____	Glaucoma.....	<input type="radio"/>	<input type="radio"/>	_____
High___/ Low___Blood Pressure.....	<input type="radio"/>	<input type="radio"/>	_____	Nervous Disorder.....	<input type="radio"/>	<input type="radio"/>	_____
Asthma.....	<input type="radio"/>	<input type="radio"/>	_____	Kidney or Urinating problems.....	<input type="radio"/>	<input type="radio"/>	_____
Hay Fever, Sinus problems.....	<input type="radio"/>	<input type="radio"/>	_____	Are you on dialysis?.....	<input type="radio"/>	<input type="radio"/>	_____
Pneumonia.....	<input type="radio"/>	<input type="radio"/>	_____	Sickle Cell Anemia.....	<input type="radio"/>	<input type="radio"/>	_____
Bronchitis, Chronic Cough.....	<input type="radio"/>	<input type="radio"/>	_____	Hemophilia, bleeding tendency.....	<input type="radio"/>	<input type="radio"/>	_____
Tuberculosis or other Lung Disease.....	<input type="radio"/>	<input type="radio"/>	_____	Other Blood disorder.....	<input type="radio"/>	<input type="radio"/>	_____
Emphysema.....	<input type="radio"/>	<input type="radio"/>	_____	Tumor or abnormal growths.....	<input type="radio"/>	<input type="radio"/>	_____
Radiation Therapy for Cancer.....	<input type="radio"/>	<input type="radio"/>	_____	Cancer.....	<input type="radio"/>	<input type="radio"/>	_____
Epilepsy.....	<input type="radio"/>	<input type="radio"/>	_____	HIV or AIDS.....	<input type="radio"/>	<input type="radio"/>	_____
High___/Low___Blood Sugar, Diabetes..	<input type="radio"/>	<input type="radio"/>	_____	Blood Transfusion.....	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Problems.....	<input type="radio"/>	<input type="radio"/>	_____	Malignant Hyperthermia.....	<input type="radio"/>	<input type="radio"/>	_____
Faint Easily.....	<input type="radio"/>	<input type="radio"/>	_____	Herpes.....	<input type="radio"/>	<input type="radio"/>	_____
Lymphatic Disease or Lymph Nodes.....	<input type="radio"/>	<input type="radio"/>	_____	Contact Lenses.....	<input type="radio"/>	<input type="radio"/>	_____

Describe any medical problems or surgery not listed on questionnaire above _____

Do you currently or have you taken any medications for the treatment of osteoporosis (ie. Fosamax, Actonel, Aredia)?

Yes No If yes, for how long? _____

Have you ever had cancer treatment that involved bone replacement drugs like the above? Yes No

Doctor Initial _____ Date _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ORAL & FACIAL SURGEONS OF OHIO ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES ****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

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3-D IMAGING INFORMED CONSENT

Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) uses a **Cone Beam 3-D Dental Imaging System (i-CAT/i-PAN)** to capture digital images.

You may have an i-CAT scan or i-PAN scan during the course of your treatment. The i-CAT scan or i-PAN scan is intended for your doctor to evaluate skeletal, and/or soft tissue structures of the face only.

Our doctors will review the scan in order to treat you for oral and maxillofacial procedures. In addition to our surgeons review of this scan, you have the option to have the entire scan reviewed by a "Medical or Maxillofacial Radiologist", located outside of our practice, to evaluate the remainder of the anatomic structures in your head, face and neck. We will arrange to have this completed for you, if choose this optional service.

The radiologist will charge a fee for this service. This fee may or may not be covered by your insurance carrier. You will be notified of the radiologist's fee prior to review of the scan.

I understand that Oral & Facial Surgeons of Ohio (Drs. Scheetz & Rekos) uses **Cone Beam 3-D Dental Imaging System (i-CAT/ i-PAN)**, to capture digital images and that I, or my dependent may have an i-CAT scan or i-PAN scan captured during the course of treatment.

_____ I **do not** wish for the i-CAT/i-PAN scan to be sent for review by a radiologist.

_____ I **would like** the i-CAT/i-PAN scan be reviewed by a radiologist. I realize that I will be responsible for any charges incurred for this review.

 Name

 Date

CONSENT FOR RELEASE OF INFORMATION

I authorize Oral & Facial Surgeons of Ohio to disclose my information to a third party recipient, such as a spouse, parent, significant other etc., as I designate below. Completion of this form is voluntary. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Address:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following:

- Information related to my dental/medical treatment
- Information related to payment of my dental/medical treatment and/or claims
- Information related to my dental/medical treatment and/or payment of dental/medical claims specifically for the care I received from _____ to _____.

 Patient's Name

 Patient's Date of Birth

 (Signature of person giving consent)

 Current mailing address

 (Print name of person giving consent)

 Date