ALASKA ORAL & FACIAL SURGERY CENTER INC.

Dr. Clay M. Van Leeuwen

Date_____

PATIENT INFORMATION

☐Mr.☐Mrs.☐Ms.☐Dr. Name (First, MI., Last)_____

Sex: ☐Male ☐Female D.O.B._____Age___Soc. Sec. #_____Drivers Lic #_____

Primary Phone #_____Secondary Phone #_____

Mailing Address_____City_____State___Zip_____

Employer_____

Emergency Contact_____Relation_____Tel #_____

Referred By_____Dentist_____Medical Doctor_____

Parent or other Guarantor Information

Name (First, Last)_____Relation_____S. S. #_____D.O.B._____

Mailing Address_____City_____State___Zip_____

Tel #_____Employer_____Work #_____

Primary DENTAL Insurance

Primary Ins Co._____

Address_____

City_____State___Zip_____Tel #_____

Name of Subscriber_____D.O.B._____

ID #_____Group #_____

Employer of Subscriber_____

Subscriber Relation_____S.S. #_____

Primary MEDICAL Insurance

Primary Ins Co._____

Address_____

City_____State___Zip_____Tel #_____

Name of Subscriber_____D.O.B._____

ID #_____Group #_____

Employer of Subscriber_____

Subscriber Relation_____S.S. #_____

Secondary DENTAL Insurance

Secondary Ins Co._____

Address_____

City_____State___Zip_____Tel #_____

Name of Subscriber_____D.O.B._____

ID #_____Group #_____

Employer of Subscriber_____

Subscriber Relation_____S.S. #_____

Secondary MEDICAL Insurance

Secondary Ins Co._____

Address_____

City_____State___Zip_____Tel #_____

Name of Subscriber_____D.O.B._____

ID #_____Group #_____

Employer of Subscriber_____

Subscriber Relation_____S.S. #_____

Is This visit related to an accident?

Automobile: ☐ Yes ☐ No / Work Related: ☐ Yes ☐ No / Other: ☐ Yes ☐ No

Date of Injury_____Claim number_____

Insurance Company handling this claim_____

Name of Attorney / Adjustor_____Tel. #_____

Financial Policy: Fees and Payments

This is an agreement between Alaska Oral & Facial Surgery Center Inc., as creditor, and the Patient/Debtor named on this form. By executing this agreement, you are agreeing to pay for all services that are rendered.

Payment & Billing: At each visit you are required to pay the estimated amount that your insurance does not cover. Your payment is due at the time of service each time you come in. If you have no insurance, you are expected to pay in full at each time of service. All patients are responsible for providing complete, accurate insurance information, including a current copy of your insurance card and your driver's license. If you fail to provide this information, we will not be able to bill your insurance for you and you will be required to pay in full at the time. We can provide you with an estimate for your surgery and your co-pays upon request; however it is just that, an estimate. Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility. We are not responsible for knowing what your insurance coverage is or what that coverage includes. Insurance is a contract between you and your insurance company. We are not a party to this contract. As a courtesy we

will bill your primary and secondary insurance. Additional insurance filing is your responsibility. Payment is due by the patient at 90 days regardless of insurance. It is your responsibility to see that your insurance pays on time.

Change of Insurance Status: It is your responsibility to notify this office of any changes in your insurance coverage and provide new insurance information at the time of service so that we may bill the correct insurance for you. If you fail to provide this information at the time of service, we will be unable to bill your insurance and you will be expected to pay in full at the time of service.

Accident Claims: Often companies do not pay on accident claims until the entire claim settles. We may file your claim for you however; payment is expected at the time of service.

Preferred Provider: Dr. Sutley is not a preferred provider with any insurance company. It is your responsibility to know what your insurance plan pays and understand your individual coverage.

Charges to Account: We shall have the right to cancel your privilege to make charges to your account at any time. Future services would then need to be paid in full at the time of service.

Returned checks: There is a $25.00 fee for any checks returned by the bank.

Refund Checks: When all of your treatment is complete and insurance has paid, a refund check will be sent. In the event a refund check is lost or damaged there will be a $25.00 fee to stop payment and reissue a new check.

Outside Testing: Please be advised that you will be billed separately for any diagnostic testing done outside our office, i.e. pathology, MRIs, etc. This billing will come from the office where your testing is done.

Post-Operative Patients: The price of your surgery includes a 90 day post operative period. This means that your follow up office visits within 90 days from the date of your surgery are included in the cost of your surgery. However, x-rays, supplies and additional surgical procedures are not included and will be an additional cost.

Collections: All accounts over 90 days are expected to be paid in full by the patient regardless of insurance coverage. We are unable to await payment on your account while you file appeals with your insurance companies. If your insurance then makes additional payment, we will be glad to refund you. If your account becomes past due, we will take the necessary steps to collect this debt. All accounts that are turned over to collections will have interest added to the balance of your account. If your account is referred to an attorney, you agree to pay all attorney fees which incur plus court costs. Once you have an account placed with collections, you will need to settle that account first before returning for additional treatment.

Waiver of Confidentiality: You understand that if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at this office may become a matter of public record.

CHAMPUS and/or TRICARE: Dr. Sutley is not a certified provider and is non-authorized to provide services to patients with CHAMPUS/TRICARE insurance. I acknowledge that this provider is NOT a CHAMPUS/TRICARE certified provider and does not accept CHAMPUS/TRICARE insurance for payment. I agree that I will be personally responsible for the payment in full of all services and will not be able to bill CHAMPUS/TRICARE for reimbursement. *METLIFE DENTAL IS ACCEPTED.*

We appreciate and value each patient and realize that the present economy is difficult for all of us. It is with regret that these policies need be.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Alaska Oral & Facial Surgery Center Inc. for benefits otherwise payable to me.
I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding the Notice.

Please Print Patient Name: _____

Patient Signature: _____ **Date:** _____

Parent / Legal Guardian Signature if patient is a minor: _____

ALASKA ORAL & FACIAL SURGERY CENTER INC.

Dr. Clay M. Van Leeuwen

HEALTH HISTORY

Although oral surgeons primarily treat the area in and around your mouth, you mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important Interrelationship with the care, which you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit_____

	Yes	No
1. Are you in good health?_____Height_____Weight_____	☐	☐
2. Have there been any changes in your general health in the past year?_____	☐	☐
3. Are you under the care of a physician?_____Date of last visit_____	☐	☐
a. If so, what are you being treated?_____		
4. Have you had any illness, operation or hospitalized in the past five years?_____	☐	☐
a. If so, describe_____		
5. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around mouth?_____	☐	☐
a. If so, describe where_____		
6. Do you have a prosthetic join/implant? If so, describe where_____	☐	☐
7. Have you had a heart valve replacement or vascular graft?_____	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE……

	Yes	No	NOTES		Yes	No	NOTES
Rheumatic fever				Thyroid Trouble			
Damaged heart valves/ Mitral valve prolapse				Swollen ankles, arthritis or joint disease			
Heart murmur				Diabetes			
High Blood Pressure				Low blood sugar			
Chest pain / angina				Kidney trouble			
Heart attack(s)				Are you on dialysis			
Irregular heart beat				Osteoporosis / Osteopenia			
Cardiac pacemaker				Osteonecrosis			
Heart surgery				Stomach ulcers			
Bronchitis, chronic cough				Contagious diseases			
Asthma				Sexually transmitted diseases			
Hay fever / sinus problems				Are you immunosuppressed Possibly from transplant surgery, etc			
Snoring / sleep apnea				Problems with the immune system possibly from medication/surgery, etc.			
Difficult breathing / lung trouble				Delay in healing			
Tuberculosis				A tumor or growth			
Emphysema				Radiation therapy / Chemotherapy			
Do you smoke				Chronic fatigue / night sweats			
Do you use chewing tobacco				Are you on a diet			
Blood transfusion				A history of drug abuse			
Blood disorder such as anemia				A history of alcohol abuse			
Bruise easily				Contact lenses			
Bleeding tendency / abnormal bleed				Eye disease / glaucoma			
Hepatitis, jaundice, or liver disease				Mental Health problems			
Infectious mononucleosis				A removable dental appliance			
Gallbladder trouble				Pain and clicking of jaws when eating			
Fainting spells				Malignant hyperthermia			
Convulsions / epilepsy				**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat / drink in the last 6 hrs & who is driving you home			
Stroke							
HIV / AIDS							

MEDICATION – Are you now taking or have you taken…….	**Yes**	**No**	**NOTES**
Any kind of medication, drug, pills			
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)			
Have you ever taken diet pills			
Any natural product, herbal, supplement or homeopathic remedy			
Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel?			

Have you ever taken tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? ☐ Yes ☐ No
If yes, please list:

Please list any medications you are currently taking:

Please list any vitamins, herbs or herbal supplements you are currently taking:

FAMILY HISTORY	**Yes**	**No**
Cancer		
Diabetes		
Heart Disease		
Anesthetic Problems		

Section for Women ONLY

Is there a possibility of pregnancy? ☐ Yes ☐ No
Expected delivery date_____
Are you nursing ☐ Yes ☐ No
Are you taking birth control pills ☐ Yes ☐ No

LATEX ALLERGIES (after handling or wearing latex products have you experienced:

	Yes	**No**
Chapping or cracking of skin		
Runny Nose or Congestion		
Itching (hands, eyes, ect.)		
Redness		
Swelling		
Hives		

ALLERGIES – Are you allergic to, or had a reaction to…..	**Yes**	**No**	If YES Check all of the reactions you have or experience
Local Anesthetic (numbing med.)			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Penicillin, Tetracycline, Other Antibiotics			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Iodine / IVP Dye			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Cephalosporin's			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Sulfa Drugs, Sulfites			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Sodium pentothal, Valium, or other tranquilizers			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Aspirin			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Codeine or other narcotics			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Other medications			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Soy			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Eggs / Yolk			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Tape			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Shellfish			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Avocado			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Raw Potato			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Chestnuts			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Milk			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Peaches, Banana, Kiwi, Papaya, Passion Fruit			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
Tomato			☐Nausea/Vomiting ☐Rash/itch ☐Difficulty Breathing ☐Other
NO KNOWN ALLERGIES			**Please initial to the left if no known allergies**

Responsibility and Authorization

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Alaska Oral & Facial Surgery Center Inc. responsible for any errors or omissions that I have made in the completion of this form.

I authorize my Alaska Oral & Facial Surgery Center Inc. surgeon and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Patient Signature:_____ Date:_____
Parent / Legal Guardian Signature if patient is a minor:_____
Witness:_____Doctor:_____Date:_____

Information Release

During the course of your treatment, it is fairly common for frequent communication with a family member, physician, caregiver or a friend to take place, either in the office or by telephone.

In order to maintain confidentiality of dental/medical information to assure that we are communicating with the right person, we request that you authorize the staff to release your information to a specific family member, physician, caregiver or friend.

- ☐ I **DO NOT** want my information released to anyone.
- ☐ I authorize Dr. Stephen H. Sutley and/or staff to release my treatment/financial information to:

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Print Patient Name: _____ Date:_____

Patient Signature:_____ Date:_____

Parent / Legal Guardian Signature if patient is a minor:_____

You have the right to revoke this consent provided that you do so in writing, except to the extent that we have already used and disclosed the information that began prior to your consent and which it relies on your Protected Health Information