M / F

Patient's Name Today's Date Gender Age

Person completing form if other than patient and relation:_____

HEALTH HISTORY *Oral Surgery of Springfield*

Please use the reverse side if more space is needed and circle words below that describe your conditions

Answer all questions by circling Yes (Y) or No (N). All responses are kept confidential in accordance with HIPPA .

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

_____

6. **Height _____ Weight _____**
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis? or Fibromyalgia.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation (X-ray) treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - S. Have you ever taken Bisphosphonate drugs such as Aredia, Zometa, Fosamax or Actonel, for osteoporosis or chemotherapy as for multiple myeloma?. . . .. . .Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (i.e.Coumadin) (Blood Thinners)?...Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, prednisone etc.)?.....Y N
   - F. Any steroids in the last two years?.....Y N
   - G. Any tranquilizers or Antidepressants?.....Y N
   - H. Insulin or Oral Diabetic drugs?.....Y N
   - I. Digitalis, Inderal, Nitroglycerin or heart drugs? Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin, amoxicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products? .....Y N
   - G. Other allergies or reactions? Please, list.....Y N

     _____
10. Have you ever smoked tobacco products .....Y N
    If so how many years did you smoke:_____
    If you quit then when did you quit: _____
    If you still smoke then how much per day now? _____
11. Have you ever used smokeless tobacco or chew…….....Y N
    If so how many years:_____
    If you quit then when did you quit?_____
12. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
13. Have you had any serious problems associated with any previous dental treatment?.....Y N
14. Have you or an immediate family member had any problem with intravenous or general anesthesia?.....Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
16. Do you wish to talk to the doctor privately about anything? .....Y N
17. **FOR WOMEN ONLY**
    - A. Pregnant or **<u>any chance</u>** you might be Pregnant?...Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) interfere with the effectiveness of oral contraceptives. You will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or medication is completed. Please consult with your physician for further guidance. Do you understand? Y N

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

_____ _____

Date Signature of Patient/ Guardian

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ASSIGNMENT OF BENEFITS

I consent to medical/dental examination, laboratory procedures, and other studies ordered by physicians, advanced practice nurses, physician assistants or other health care providers of Frank A. Cornella, D.D.S., M.D., P.C.

I authorize Frank A. Cornella, D.D.S., M.D., P.C. to disclose to the Social Security Administration or its intermediaries or carriers, and/or my insurance company, any information relating to the identity, diagnosis, programs, or treatment of the patient. This may be done electronically if available. I understand the purpose of this disclosure is to facilitate the payment of insurance benefits. This is a direct assignment of my rights and benefits under this policy.

I request payment of insurance benefits to be made to Frank A. Cornella, D.D.S., M.D., P.C. and authorize any holder of medical information including, but not limited to insurance companies, adjusters, and attorneys to release this information to my insurance company as well as any information needed to determine benefits payable for services.

In consideration for services rendered, I hereby assign to Frank A. Cornella, D.D.S., M.D., P.C. benefits to which I am entitled under the terms of my insurance policy(ies), **and agree to be responsible for services not paid in whole or in part by my insurance company,** which I hereby certify is in full force and effect. This authorization will remain in force and effect until revoked by me in writing. I have read all the information on this sheet and verify the information I am giving is true and correct to the best of my knowledge. I will notify this office of any changes of this information.

Any charges deemed medically or dentally unnecessary by your insurance company become your responsibility.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Frank A. Cornella, D.D.S., M.D., P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf when there are unreasonable delays in receiving payment from my insurance provider.

NOTE: If you are found to have a condition, such as cancer, which must be reported to a county, state or national health agency your diagnosis will be reported as required by law to the appropriate agency.

SIGNATURE:_____ DATE: _____

Financial Agreement

We are Preferred Providers for many insurances. For an exam (with insurance), a fee code will be filed with your insurance. For a procedure (with insurance), **an estimated patient portion is due the day of the procedure. For a procedure (with insurance) to be scheduled, the estimated patient portion is required to be paid in order to schedule. If you request a predetermination, we will submit an inquiry to your insurance for that ESTIMATE of cost. This is only an ESTIMATE. As your insurance policy is a contract between you and the insurance company, we CANNOT guarantee the accuracy of information. For exams and procedures *without* insurance, the cost is due the day of service.**

Although we will assist in filing our insurance claim, payment to us is **solely your responsibility**. If insurance does not pay in full in a timely manner, we will require you to pay any balance due.

When there is no insurance involved, a payment of 50% of the estimated fee will be due at the time of scheduling and then the remainder is due at time of service. But if services are rendered in one visit, it would be due at that time.

Please be advised due to occasional issues of delivery with the USPS mail, that if we issue you a refund check via mail to the address you supply, and that check does not reach you by mail in a timely fashion, two instances may apply.

1. You may wait for the initial refund check to expire, which takes 6 months (180 days), and we will issue you a new refund check.

2. You may request a new refund check to be issued by our office, before the 6 month expiration, to be picked up at our office in person, if you choose, in which case a $36 stop payment will be deducted from your newly issued refund check.

Always, with any refund check you are owed by our office, you are welcomed to come to the office with photo ID and pick up that check in person.

To avoid potential ethical and legal issues, and to help keep the cost of care as low as possible for all our patients, this office does not extend professional courtesy.

Delinquent accounts will be sent to collections. Signing this also constitutes a release of any information and documentation needed for collection purposes. **Returned checks will be subject to a $30 fee.**

Signature:_____ Date:_____