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VALLEY ORAL SURGERY, P.C.

LARRY R. MEADOR, D.D.S.

PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY

*** Please Print Clearly ***

OFFICE USE ONLY
Initials:
_____ Added
_____ Updated
Fees:_____
F/C:_____

GENERAL INFORMATION

Full Name: _____ Home Phone:_____
Preferred Name: _____ Cell Phone:_____
Street Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate:_____ Sex: _____ Marital Status: _____ S.S.#: _____
Patient Employed by: _____ How Long?_____ Occupation: _____
Employer's Address: _____ Phone: _____
Parent/Spouse Name (Circle one):_____ Occupation:_____
Parent/Spouse Employed by: _____ Phone: _____
Person responsible for patient's bill: _____ S.S.#:_____
Relation to patient:_____ Address:_____ Employer: _____
Person to notify in case of emergency (if different from above): _____
Phone (during the day): _____ Relationship: _____
Have you ever been a patient here before?_____ Approximate date: _____
Have any members of your family been patients here before?_____ Name: _____ Approx. Date: _____
Family Dentist: _____ Orthodontist: _____
Family Physician: _____ Who referred you to this office? _____

INSURANCE INFORMATION

In order for us to properly file for services rendered in our office, the following information must be supplied. If the information needed is not provided, payment is due when services are rendered unless other arrangements are made.

Do you have Dental Insurance? ☐ Yes ☐ No Relationship of patient to policyholder: ☐ Self ☐ Spouse ☐ Child
Name of Policyholder _____ S.S.# of Policyholder_____
ID # _____
Name of Dental Insurance Company _____ Group # _____
Policyholder's Place of Employment _____ Date of Birth _____

Do you have Medical Insurance? ☐ Yes ☐ No Relationship of patient to policyholder: ☐ Self ☐ Spouse ☐ Child
Name of Policyholder _____ S.S.# of Policyholder_____
ID # _____
Name of Medical Insurance Company_____ Group # _____
Policyholder's Place of Employment _____ Date of Birth _____

ASSIGNMENT OF INSURANCE BENEFITS
GUARANTEE OF PAYMENT

AS A GENERAL RULE, IT IS OUR OFFICE POLICY FOR FEES TO BE PAID AT THE TIME OF SERVICE. A MINIMUM FINANCE CHARGE OF FIFTY CENTS PER MONTH OR FINANCE CHARGES AT THE RATE OF 1% PER MONTH (12% APR) WILL ACCRUE ON ANY UNPAID BALANCE 90 DAYS FROM THE DATE OF SERVICE.

PATIENTS WHO CARRY HEALTH CARE INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT AND NOT TO THE INSURANCE COMPANY. AS A COURTESY, WE WILL BE HAPPY TO SUBMIT INSURANCE CLAIMS TO YOUR PRIMARY AND SECONDARY INSURANCE CARRIERS. HOWEVER, DUE TO THE EXTENSIVE AMOUNT OF ADMINISTRATIVE TIME INVOLVED, WE WILL NOT FILE CLAIMS FOR COVERAGE ABOVE PRIMARY AND SECONDARY, NOR WILL WE BE RESPONSIBLE FOR "RESUBMITTING" ANY CLAIMS FILED BY OUR OFFICE OR BY YOU.

EVEN THOUGH AN INSURANCE CLAIM IS FILED, YOU WILL RECEIVE A STATEMENT EACH MONTH IF YOUR ACCOUNT HAS A BALANCE DUE. THIS OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. IN CASES WHERE INSURANCE CLAIMS ARE PENDING, INTEREST ON UNPAID BALANCE WILL ACCRUE 90 DAYS FROM THE DATE OF SERVICE.

YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT WITHIN 90 DAYS. IN THE EVENT YOUR ACCOUNT BECOMES SERIOUSLY DELINQUENT AND IS TURNED OVER TO OUR ATTORNEY FOR COLLECTION, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL OF YOUR ACCOUNT PLUS COLLECTION COSTS AND 33% ATTORNEY'S FEES.

FOR SERVICES RENDERED, THE UNDERSIGNED HEREBY ASSIGNS ALL INSURANCE BENEFITS PAYABLE TO OR ON BEHALF OF THE UNDERSIGNED TO VALLEY ORAL SURGERY, P.C. THIS SIGNATURE SERVES AS A REQUEST FOR PAYMENT FOR SERVICES RENDERED BY LARRY R. MEADOR, D.D.S. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(S). I UNDERSTAND THAT INSURANCE OVERPAYMENTS WILL BE RETURNED TO ME UP TO THE AMOUNT OF MY DEPOSIT. ANY OVERPAYMENTS IN EXCESS OF MY DEPOSIT WILL BE REFUNDED TO MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE CONTRACT(S).

X

DATE SIGNATURE RELATIONSHIP TO PATIENT IF MINOR

For patients' convenience, we accept Mastercard, Visa and Discover.

OVER ⇨

PATIENT NAME: _____

MEDICAL INFORMATION:

What complaint brought you to this office? _____

Give details: _____

Please check the appropriate box only if you have had any of the following conditions:

- ❑ Heart Disease (or Heart Attack)
- ❑ Chest Pain (Angina)
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Liver Disease (Cirrhosis or Hepatitis)
- ❑ Stomach or Intestinal Disorder
- ❑ Kidney Disease
- ❑ Thyroid Disease
- ❑ Blood Disease
- ❑ Anemia
- ❑ Sickle Cell Disease or Trait
- ❑ Bleeding Disorder
- ❑ Seizure Disorder
- ❑ Nervous Disorder
- ❑ Stroke
- ❑ Malignant Hyperthermia
- ❑ Cancer
- ❑ Venereal Disease
- ❑ Herpes
- ❑ AIDS (HIV Infection)
- ❑ Arthritis
- ❑ Glaucoma
- ❑ Diabetes Type I ___ Type II ___
- ❑ Joint Replacement
- ❑ High Cholesterol
- ❑ Sleep Apnea
- ❑ Pain Management

❑ Please describe any present or past use of tobacco products. If cigarettes . . . pks/day?_____ #yrs. smoked? _____
If you have quit, date_____ . If other tobacco products or vaping, please describe _____

❑ Other, please describe _____

NO		YES
❑	Any known allergies (all types)? Please List _____	❑
❑	Are you now or have you ever taken oral bisphosphonate drugs? (**Bone Strengthening Medicine**)	❑
❑	Are you taking any medications or drugs? Please list names & dosages of each drug _____	❑
❑	Have you taken or are you taking steroids (cortisone, prednisone)?	❑
❑	Are you taking any anticoagulants (blood thinners)?	❑
❑	Are you presently under the care of a physician? Physician's Name:_____ Why?_____	❑
❑	Have you had any major surgery or serious illness? If so, when and why?	❑
❑	Are you pregnant? If so, how many months?_____ Physician: _____	❑
❑	Are you now or have you been under psychiatric care?	❑
❑	Have you or any member of your family ever had a complication from a local or general anesthetic?	❑
❑	Have you ever received x-ray (radiation) therapy for the treatment of a disease?	❑
❑	Do you wear contact lenses?	❑
❑	Do you now or have you ever used alcohol or other drugs in excess?	❑
❑	Do your jaws click and pop or do you have persistent facial pain/headaches?_____	❑
❑	Do you have any abnormal growths in your mouth? Present how long?_____	❑

FOR OFFICE USE ONLY:

Date	Proposed Procedure	Fee Estimate

TIME NEEDED_____ _____

Signature of Patient or Legal Guardian

HEALTH HISTORY UPDATE
(To be obtained by clinical staff)

DATE	INITIALS