Welcome to the Oral Maxillofacial Surgery Practice of Christopher A. Buttner, D.D.S.

Initial Exam Date: _____ Subsequent Exam Date: _____

Patient: (Mr., Mrs., Ms., Dr.) First Name_____ M.I._____ Last Name_____

Nickname _____ ❑ Male ❑ Female Date of Birth _____ / _____ / _____ Social Security # _____

School Name/Address _____ ❑ Full Time Student ❑ Part Time Student ❑ N/A
*Proof of student status may be required for patients 18 years or older.

Street_____ City _____ State_____ Zip_____

Home Phone # (_____) _____ Cell Phone # (_____) _____

Employer_____Tel. # (_____) _____ Ext._____

Dentist _____ Physician_____ Referred By_____

Driver's Lic. # _____ Nearest relative not living with you_____ Tel.# (___) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

If responsible party is other than above: ❑ Spouse ❑ Parent ❑ Other ❑ Custodial Parent

Name _____ Soc. Sec.#: _____

Home Phone # (_____) _____ Cell Phone # (_____) _____

Street_____ City _____ State _____ Zip _____

Employer_____Tel. # (_____) _____ Ext._____

PRIMARY DENTAL INSURANCE

Employer_____ Bus. Address _____

Bus. Tel.#: _____Plan _____

Ins. Co. Name_____Address_____Phone: (___)_____

Group #: _____ **Group Name:** _____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth: _____S.S. #: _____

Do you have Medicaid: ❑ Yes ❑ No

PRIMARY MEDICAL INSURANCE

Employer_____

Ins. Co. Name_____

Address_____

_____ Phone: (___) _____

Group #: _____ **Group Name:**_____

Insured Party _____ Relation_____

Sex: ❑ M ❑ F Date of Birth: _____

S.S. #: _____

SECONDARY MEDICAL INSURANCE

Employer_____

Ins. Co. Name_____

Address_____

_____ Phone: (___) _____

Group #: _____ **Group Name:**_____

Insured Party _____ Relation_____

Sex: ❑ M ❑ F Date of Birth: _____

S.S. #: _____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your 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, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Medical Alert Sticker

Reason for today's office visit: _____

_____

Pain scale (0 = no pain, 10 = severe pain) 0 1 2 3 4 5 6 7 8 9 10 (Please circle one)

Height _____ Weight _____ Age _____

Answer all questions by circling Yes (Y) or No (N)

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? ..... Y N
   If so, describe: _____
   _____
   _____
   _____

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
1	Rheumatic fever?				27	Stroke?			
2	Damaged Heart Valves/Heart Murmur Mitral Valve Prolapse?				28	Thyroid disease?			
3	Heart Surgery/Valve Replacement Bypass Surgery?				29	Diabetes?			
4	High blood pressure?				30	Low blood sugar?			
5	Low blood pressure?				31	Kidney disease?			
6	Chest pain, angina?				32	Are you on dialysis?			
7	Heart attack(s)?				33	Swollen ankles, arthritis or joint disease?			
8	Irregular heart beat?				34	Stomach ulcers, colitis, reflux?			
9	Cardiac pacemaker?				35	Contagious diseases?			
10	Prosthetic joint or implant?				36	Sexually transmitted diseases?			
11	Pneumonia?				37	Any disease or drug that has depressed your immune system?			
12	Asthma, bronchitis, chronic cough?				38	Delay in healing?			
13	Hay fever / Sinus problems?				39	A tumor or growth?			
14	Tuberculosis?				40	Radiation therapy / chemotherapy (for cancer)?			
15	Emphysema, shortness of breath?				41	Chronic fatigue / night sweats?			
16	Other lung trouble?				42	Are you on a diet?			
17	Do you smoke or chew tobacco?				43	Do you use Drugs (Ex. Cocaine)?			
18	Blood transfusion?				44	A history of alcohol abuse?			
19	Blood disorder such as anemia?				45	Contact lenses?			
20	Bruise easily/bleeding tendency (abnormal bleeding)?				46	Eye disease / glaucoma?			
21	Blood clots in your legs				47	Mental health problems?			
22	Jaundice, liver disease, hepatitis?				48	A removable dental appliance?			
23	Infectious mononucleosis?				49	Pain, clicking, popping of the jaw joint?			
24	Gallbladder trouble?				50	Malignant Hyperthermia?			
25	Fainting spells, dizziness?				51	Do you have any other disease not listed above?			
26	Seizures, convulsions, epilepsy?								

MEDICATION

	ARE YOU NOW TAKING...	Yes	No	DRUG NAME(S)
52	Aspirin or drugs like Motrin, Aleve?			
53	Anticoagulants? (Ex. Coumadin, Plavix)			
54	High Blood Pressure Medication?			
55	Insulin or oral anti-diabetic drug?			
56	Steroids? (Ex. Prednisone)			
57	Bisphosphonates (Fosamax, Boniva, Actonel, Zometa, Aredia)			
58	Please list all other medications taken including over the counter, herbal remedies, vitamins.			

ALLERGIES

	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	NOTES
59	Local anesthetics?			
60	Codeine or other narcotics?			
61	Motrin / Ibuprofen / Aspirin?			
62	Sodium pentothal, valium, or other tranquilizers?			
63	Latex, Rubber?			
64	Penicillin/Amoxicillin?			
65	Sulfites (Preservatives)/Eggs?			
66	Sulfa Antibiotics?			
67	Other Antibiotics?			
68	Please list other drug allergies			

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes ❑ No ❑

Is there a **family history** of: 301. **Cancer** Yes ❑ No ❑ 302. **Diabetes** Yes ❑ No ❑ 303. **Heart Disease** Yes ❑ No ❑ 304. **Anesthetic Problems** Yes ❑ No ❑

IN CASE OF EMERGENCY, CONTACT: Name: _____ Tel # H: (___) _____ Wk: (___) _____

(MEN skip to line 71) WOMEN COMPLETE THIS SECTION

		Yes	No	
69	Is there a possibility of pregnancy?			
70	Estimated delivery date? ___/___/___			
71	Are you nursing?			
72	* Are you taking birth control pills?			

* I understand that antibiotics (such as penicillin) and other medications may alter the effectiveness of birth control pills. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics and other medication is completed. Consult your physician/gynecologist for assistance regarding other methods of birth control.

71. 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 my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

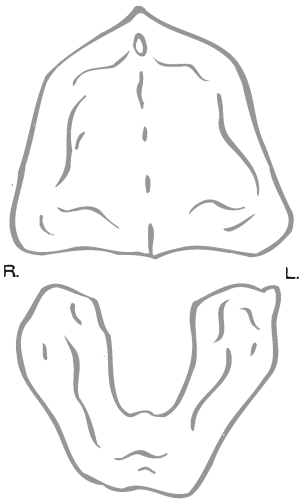
Signature of patient: _____ **Date:** _____

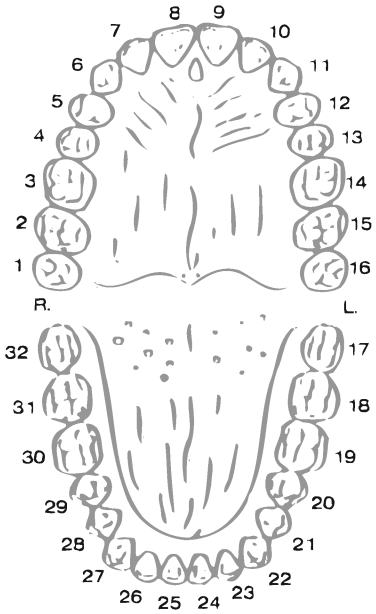
(Parent or Guardian if minor)

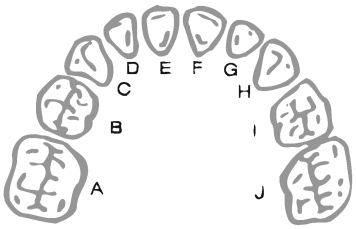
CHARTING

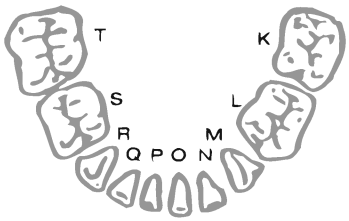
LOCAL ❑ _____
IV SED ❑ _____

Scheduling
30' ❑ _____
45' ❑ _____
60' ❑ _____
Other _____









CHRISTOPHER A. BUTTNER, D.D.S. FINANCIAL POLICY AND AUTHORIZATION

➢ We are happy to file an insurance claim to your primary insurance carrier for you. Please understand that insurance companies rarely reimburse the full amount, usually paying between 50-80% of the cost under the maximum annual benefit (usually $1000-$2000) after yearly deductibles have been met by the insured. Also insurance companies do not routinely cover many oral surgery procedures. Therefore, ***we collect a standard 30% of COVERED benefits for most insurance companies payable on the day of the surgery appointment. Non-covered benefits require payment in FULL prior to the surgical procedure.***

- We will be happy to send a predetermination request to your insurance company. However we will not schedule your surgery appointment until we receive a reply (generally 4-6 weeks).
- ***After*** *the insurance has paid you will promptly receive a* ***refund or a bill*** *whichever is applicable.* If you have a balance due after insurance has paid the balance is payable in full within fifteen days of receipt of a statement.
- If the patient is 18 years or older, please indicate whom the bill or refund should be addressed to:

  Name _____ Address _____
- If your insurance company has not reimbursed us in full in 60 days of filing your claim we will send a statement to the responsible party and the unpaid balance becomes due and payable within fifteen days.
- General anesthesia/IV sedation is not usually covered for non-surgical tooth extractions.

➢ ***We require payment in full for exam and any X-rays on the day of service.***

- Insurance companies will usually only pay for one or two office visits per year. If you were examined by your general dentist and referred to this office, your exam fee at this office may not be covered.
- Insurance companies will generally pay for a Panorex X-ray (full mouth/jaw x-ray) every two-five years. If the diagnostic quality of X-ray(s) provided by your general dentist are not acceptable we may require a new X-ray for today's exam visit and it may not be covered by your insurance company.

➢ ***Payment in full is required for tooth extraction with local anesthetic when done the same day as the examination.***

➢ Financial arrangements are individualized for every patient for extraction of multiple teeth for the placement of dentures or partials. Insurance benefits are frequently used up for the year with the fabrication of the dentures. Alveoplasty (smoothing of bone for denture placement) is often not a covered expense when performed concurrent with dental extractions. Implant placement is occasionally a covered benefit.

➢ When a **biopsy procedure** is performed the specimen will be sent to a lab. You will be billed separately by the lab for their diagnostic services. The Pathology Lab service fees are determined by the pathology lab.

➢ If you do not provide us with complete and accurate insurance information you will be required to pay for all professional services in full at the time of service.

➢ Insurance companies require patients who are ***full time*** **students over 18 years old** to provide a copy of his/her student schedule for the current semester.

➢ It is our policy to have ***the insured*** **file all secondary insurance claims.** Insurance Company policies regarding secondary insurance coverage is extremely varied and often times ambiguous. As a consequence, we are unable to effectively administer a program to file and resolve secondary insurance claims. We will create a secondary insurance claim for you after the primary insurance has issued an explanation of benefits (EOB).

➢ **We DO NOT accept out of state checks.**

➢ Checks returned due to insufficient funds are processed by TELECHECK® for collection and assessed a $30.00 fee.

➢ A service charge of 1.5% (18%APR) will be charged to outstanding accounts greater than 30 days.

➢ Outstanding accounts greater than 90 days will be turned over to a collection service for collection.

➢ Patients wishing to finance treatment fees may be eligible for commercial financing through a financing company. Details available on request.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay the deductible amount, co-payment or any other balance not paid by your insurance company. The responsible party understands and agrees to the financial policy outlined above and will be responsible for all fees for treatment. The signature below is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ _____ **Witness:** _____

Date: **Signature of Patient (Parent or Guardian if minor):**

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

DATE	ADMINISTRATIVE NOTES