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

Initial Exam Date: _____ EMAIL ADDRESS: _____

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

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

Street_____ City _____ State_____ Zip_____

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

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

Employer_____Tel. # (_____) _____ Ext._____

Dentist _____ Physician_____ Referred By_____

Driver's Lic. # _____ Name of 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 _____ Date of Birth _____ / _____ / _____ Social Security # / Last Four_____

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

Street_____ City _____ State _____ Zip _____

Employer_____Tel. # (_____) _____ Ext._____

PRIMARY DENTAL INSURANCE

Employer _____

Bus. Tel.#: _____ Plan _____

Ins. Co. Name_____

ID #: _____ **Group #:**_____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____ / _____ / _____

SECONDARY DENTAL INSURANCE

Employer _____

Bus. Tel.#: _____ Plan _____

Ins. Co. Name_____

ID #: _____ **Group #:**_____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____ / _____ / _____

PRIMARY MEDICAL INSURANCE

Employer_____

Ins. Co. Name_____

Address_____

_____ Phone: (_____) _____

ID #: _____ **Group #:** _____

Insured Party _____ Relation_____

Sex: ❑ M ❑ F Date of Birth _____ / _____ / _____

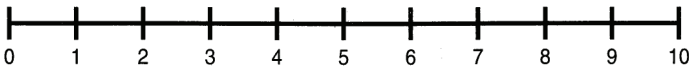
HEALTH HISTORY

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) 

(Please circle one)

Height_____ Weight_____ Age_____

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

1. Has there been any change in your general health in the past year? ..... Y N
2. Are you now under a physician's care for a particular problem? ..... Y N

_____

4. 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	Damaged Heart Valves/Heart Murmur Mitral Valve Prolapse, Rheumatic fever?				27	Thyroid disease?			
2	Heart Surgery/Valve Replacement/Bypass Surgery?				28	Diabetes?			
3	High blood pressure?				29	Low blood sugar?			
4	Low blood pressure?				30	Kidney disease?			
5	Chest pain, angina?				31	Are you on dialysis?			
6	Heart attack(s)?				32	Swollen ankles, arthritis or joint disease?			
7	Irregular heart beat/Atrial fibrillation?				33	Stomach ulcers, colitis, reflux?			
8	Cardiac pacemaker/defibrillator?				34	Contagious diseases?			
9	Prosthetic joint or implant?				35	Sexually transmitted diseases?			
10	Pneumonia, bronchitis, chronic cough?				36	Any disease or drug that has depressed your immune system?			
11	Asthma?				37	Delay in healing?			
12	Hay fever / Sinus problems?				38	A tumor or growth?			
13	Tuberculosis?				39	Radiation therapy / chemotherapy (for cancer)?			
14	Emphysema, shortness of breath?				40	Chronic fatigue / night sweats?			
15	Other lung trouble?				41	Are you on a diet?			
16	Do you smoke or chew tobacco?				42	Do you use Drugs (Ex. Cocaine)?			
17	Blood transfusion?				43	A history of alcohol abuse?			
18	Blood disorder such as anemia?				44	Eye disease / glaucoma?			
19	Bruise easily/bleeding tendency (abnormal bleeding)?				45	Mental health problems? Depression? Anxiety?			
20	Blood clots in your legs				46	A removable dental appliance?			
21	Jaundice, liver disease, hepatitis?				47	Pain, clicking, popping of the jaw joint?			
22	Infectious mononucleosis? When?				48	Malignant Hyperthermia?			
23	Gallbladder trouble?				49	Osteoporosis / Osteopenia			
24	Fainting spells, dizziness?				50	Cannabis Use?			
25	Seizures, convulsions, epilepsy?				51	Do you have any other disease not listed above?			
26	Stroke / TIA								

MEDICATION

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

ALLERGIES

	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	NOTES		ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	NOTES
58	Local anesthetics?				63	Penicillin / Amoxicillin / Augmentin?			
59	Codeine or other narcotics?				64	Sulfites (Preservatives)/Eggs?			
60	Motrin / Ibuprofen / Aspirin?				65	Sulfa Antibiotics?			
61	Propofol, Versed, Valium or other sedatives?				66	Other Antibiotics?			
62	Latex, Rubber, Adhesives?				67	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 72) WOMEN COMPLETE THIS SECTION

68	Is there a possibility of pregnancy?				70	Are you nursing?			
69	Estimated delivery date? ___/___/___				71	* 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.

72. 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: _____

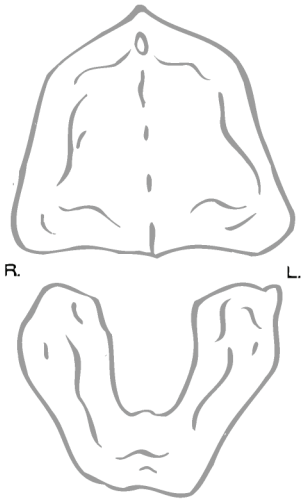
(Parent or Guardian if minor)

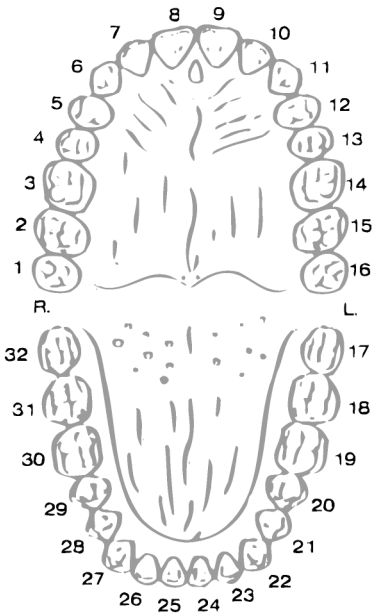
CHARTING

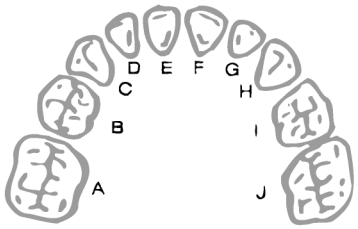
(Office Use Only)

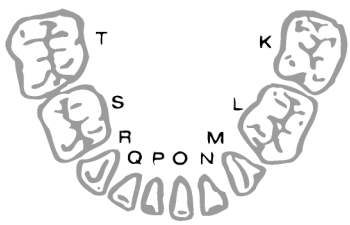
LOCAL ❑ _____
IV SED ❑ _____

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 under 18 years old, 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 may be 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.

➢ Some 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 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 to acknowledge that you have received upon request the Notice of our Privacy Practices:

❑ Signature below acknowledges that you deferred to view the Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

DATE	ADMINISTRATIVE NOTES

PATIENT DISCLOSURE INSTRUCTIONS

Notice of Privacy

Omnibus Rules

I wish to be contacted in the following manner **(check all that apply)**:

Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call-back number only

Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call back number only

Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to _____
- ☐ O.K. to text to cell phone _____
- ☐ O.K to email to _____

I allow to give my clinical information to or answer questions from (Check all that apply):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

Preferred Pharmacy:

Name: _____

Address: _____

Telephone #: _____

Please initial showing that you understand the following statements.

_____ 1. Our practice does not use your Protected Health Information (PHI) for any fundraising.

_____ 2. We are obligated to notify you (the patient) in the event of a breach of unsecured PHI.

_____ 3. If you pay in full at the time of service, you have the right to request that our office does not disclose your treatment information to a health plan. Please notify us if you do not want your insurance billed.

_____ 4. You have a right to a copy of your health records; as of now we are not currently set-up with the ability to send you electronic records.

Patient Signature (Legal Guardian): _____ Date: _____

Print Name:_____ Birth Date:_____

COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

_____ _____

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risk of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state of federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounter, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? _____
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	if yes, when? _____
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	

In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO

Symptoms – Today, or in the last 14 days

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste or smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement – By signing this document, I acknowledge that I have read the Patient Acknowledgement and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Witness Signature Date

Subsequent Visit – Acknowledgement Signature Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____