SOUTHWEST VIRGINIA ORAL AND MAXILLOFACIAL SURGERY

Samuel E. Scroggins, DMD, Updated 5/5/14

Dr/Mr/Mrs/Ms/Miss (circle) Single/Married/Divorced/Widow (circle)

Patient's Full Name:_____ Birthdate___/___/____ SS#_____

Home Address_____City_____State_____ Zip:_____

Home Phone:(___)_____Cell phone:(___)_____

Employer/School:_____Position:_____Work Phone:_____

Address:_____City:_____State:_____Zip:_____

*Parent/Spouse/Significant Other*_____Relationship:_____phone_____

Home Address: Same as above:_____Different:_____

Employer:_____Position_____Work Phone:_____

*Address:*_____City:_____State:_____Zip:_____

Have x-rays been sent to us?_____Please give any xrays and referral slips to the receptionist. Thank you.

Who is your regular dentist?_____Physician?_____

Who referred you to our office?_____

What complaint brought you to our office?_____

MEDICAL INFORMATION:

Drug Allergies_____

Please circle any health concerns that apply to you:

Heart Problems	Tuberculosis	Stroke	Osteoporosis
Chest Pain (Angina)	Liver Disease	Malignant Hyperthermia	Hepatitis
Heart Murmur	Stomach or Intestinal Disorder	Cancer	Shortness of Breath
Rheumatic Fever	Kidney Disease	Venereal Disease	Emphysema
High Blood Pressure	Thyroid Disease	Herpes	Seizure Disorder
Low Blood Pressure	Blood Disease	AIDS (HIV)	Nervous Disorder
Lung Disease	Anemia	Arthritis	Bleeding Disorder
Asthma	Sickle Cell Disease or Trait	Glaucoma	Diabetes

Other_____

Please List Name and Dosages of Daily Medication:_____

_____

Are you taking blood thinners?_____Physician's Name & Phone Number_____

Are you taking steroids (cortisone, prednisone)?_____

Are you under care of physician? Physician Name:_____Why?_____

List major surgeries and serious illness:_____

Are you now or have you ever been under psychiatric care?_____Physician?_____

Do you or do you have a family history of complications from general anesthesia?_____

Have you ever had radiation therapy?_____When?_____

Do you use tobacco ?_____ How long? _____

Do you have a history of alcohol or drug abuse?_____

Do you have persistent face pain or jaw clicking or popping?_____

Do you have any abnormal growths in your mouth? How long?_____

Do you wear contact lenses?_____

Females only: Are you pregnant?____How many months?___OB /GYN Physician name?_____Phone Number_____

Please continue on the back of this sheet

Payment Policies of Southwest Virginia Oral and Maxillofacial Surgery

Payment is due in full at the time of service for uninsured and out of network insurance patients.*

METHOD OF PAYMENT: CASH CHECKS MASTERCARD VISA DISCOVER CARE CREDIT**

Person responsible for payment:

Self:_____Other_____Relationship?_____

INSURANCE INFORMATION:

The following information is needed to file your insurance:

Dental Insurance Co.:_____ID#_____Group#_____

Policyholder's place of employment:_____

Relationship of patient to policyholder: Circle one: Self Spouse Child

Name of Policyholder:_____SS#_____DOB_____

Medical Insurance Co.:_____ID#_____Group#_____

Policyholder's place of employment:_____

Relationship of patient to policyholder: Circle one: Self Spouse Child

Name of Policyholder:_____SS#_____DOB_____

I authorize release of information necessary to process the claim and assign insurance payment to Dr. Scroggins.

*This office is in-network with Anthem, Delta Dental, MetLife PPO, and Dentaquest (Smiles for Children). Patients with this insurance, the deductible and co-pay are due the day of service. We will file out-of-network insurance for your convenience. Patients with out-of-network insurance are asked to pay in full on the day of service and we will have your insurance company reimburse you.

Insurance Policy:

Patients with insurance should remember that professional services are rendered to the patient and not to their insurance company. You will receive a monthly statement. It is your responsibility to pay the remainder in full on your statement within **30 days**. Your insurance policy is a contract between **you** and your **insurance.** We are not able to guarantee payment of your claims. When insurance is filed for you by this office, this is done as a courtesy to you. **Your bill is due in 30 days regardless of the status of your claim**. If your insurance pays only a portion of the charges submitted, or pays nothing, you are responsible for any and all charges that remain on your account. Patient questions regarding your insurance coverage and your deductible should be directed to your insurance company and not to this office. We will notify you if your claim is rejected by your insurance company. Reduction or rejection of your claim by your insurance company **does not relieve** the financial obligation you have incurred to this office.

**Care Credit - Care Credit is a payment plan to our patients who require services exceeding $500.00. It is a credit card designed specifically for the use in the dental office to assist you with paying for important dental care. Care Credit gives you the ability to make affordable payments over an extended time period. It costs nothing to apply and there are no annual fees. Please tell us if you are interested in Care Credit.

Who is the Responsible Party?

The patient is responsible for his/her bill. Each spouse is equally responsible for any expenses incurred by either spouse or minor children (this would include stepchildren living in their home.)

In instances of divorce or separation, when a minor is involved, the **PARENT WHO ACCOMPANIES THE CHILD TO THE OFFICE IS RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED.** You will be expected to pay the day of the service. We cannot bill another parent.

I fully understand the office & insurance policy of Southwest Virginia Oral and Maxillofacial Surgery.

Patient Signature_____**Date**_____

I HAVE RECEIVED A COPY OF HIPAA FORM_____(INITIAL)