HEALTH QUESTIONAIRE

PATIENT NAME: _____ PATIENT DOB:_____

1. Have you been hospitalized in the past 2 years for any reason?_____
2. Are you under the care of a physician? If so, for what specific reason?_____
3. Are you currently taking any medications?____(Please List)_____
   _____
4. Do you have any allergies? (Please List) and state reaction:_____
5. Do you use recreational or street drugs (i.e. cocaine)? _____
6. Do you consume alcoholic beverages? how often? _____ How much? _____
7. Do you smoke or chew tobacco: how often? _____ How much? _____
8. Have you ever had: toothaches orthodontics root canals extractions Periodontal problems (gums) Injury to teeth/jaws
9. Do you have a family history of any of the following: Diabetes Heart disease Bleeding disorders Cancer Other _____ Unusual dental problems
10. Females: Are you taking birth control pill? Are you pregnant? if so, est. due date_____

Please check all that apply in the section box below. A LINE THROUGH ALL CHECK BOXES is NOT ACCEPTABLE. Please CHECK off INDIVIDUALLY YES OR NO.

CHECK EACH ITEM	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Epilepsy or Seizures			Hemophilia			Ulcers		
Fainting or Dizziness			Bruise/bleed easily			Venereal disease		
Nervousness			Heart problems/angina			Thyroid disease		
Stroke			Hypertension High BP			Arthritis		
Glaucoma			Rheumatic fever			Prosthetic joints		
Cold Sores (herpes)			Heart murmur			Steroid medication		
Persistent Cough			Mitral Valve prolapsed			Alcoholism		
Emphysema			Congenital heart lesions			Cancer/Radiation		
Tuberculosis/PPD+			Heart Surgery			Kidney problems		
Asthma			Prosthetic heart valve			Diabetes		
Depression			Pacemaker			AIDS/HTLV-III		
Sinus Problems			Blood transfusion			Painful joints (jaw)		
Anemia			Liver disease			Hives		
Sickle cell disease			Yellow jaundice			Drug addiction		
G-6PD deficiency			Hepatitis type:			Unexplained weight change		

11. Do you have any other diseases not listed above? _____ _____
12. Do you need to take antibiotic(pre-med) prior to dental appointments? Name of antibiotic? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent/guardian_____ **Date**: _____

CONSENT

I authorize and give consent to any dental exam, anesthetic, operation or treatment that is necessary for treatment and diagnosis of the above named patient.

Signature of patient, parent/guardian: _____ **Date:** _____

----------***FOR DOCTOR USE ONLY***----------

Physical Status (ASA) _____

Signature of Reviewing Doctor _____ **Date**: _____

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD*☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

CELL

HOME:

CITY ST ZIP CODE

E-Mail:

Referral? ☐Yes ☐ No Referred by:

PRIMARY INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

SECONDARY INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

SECONDARY INSURANCE CARRIER

Group/Policy No.: ID No.:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

Tel:

NAME RELATIONSHIP

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all insurance submissions.

X_____

Patient signature/ Parent Signature (if patient is minor)

X_____ _____

Relationship to Patient Date

Nevada OMS
1701 W Charleston Blvd #520, Las Vegas, NV 89102
P: 702-750-9444 F: 702-750-9442

Nevada OMS
4544 S Pecos Rd, Las Vegas, NV 89121
P: 702-436-0900 F: 702-436-0636

Authorization to Release Medical Information

(Important: All blanks must be filled in)

(If more than 10 pages, please mail thank you!)

Patient Name: _____ **Birth Date: _____**
Address: _____ **SSN: _____**
_____ **TEL: _____**

Released From: _____ **Release To: _____**
_____ **_____**
_____ **_____**

Specify type of information to be disclosed:

□ Any and All Records □ Diagnostic □ Laboratory Results Only
□ Immunizations □ Chart Notes Only □ Consultations Only
□ Other:_____ Time Period:_____

I understand as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.

I understand the Practice will not condition my treatment, payment enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization, I understand I will be notified the same.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

Without expressed written revocation, this consent expires after one year.

_____ _____
Signature of: _____ PATIENT PRINTED NAME
_____ PARENT/GUARDIAN
(If patient is a minor)

DATE: _____

NevadaOMS
Patient Financial Policy Notice

Thank you for selecting Michel Daccache Oral and Maxillofacial Surgery for your dental care services. We are committed to providing the highest quality of care. As a courtesy to you, if applicable, we will bill your insurance company for any services rendered.

You will be given a Treatment Plan Estimate detailing your estimated patient co-pays for any/all prescribed dental work. Insurance remittance estimates are provided as a courtesy and are based on current information collected from insurance carriers. While we would like to advise you of your exact financial obligation before your date(s) of service, the scale of different insurance plan designs make it extremely difficult. Your co-payment or patient portion may vary based on actual payments made by your insurance provider.

Claims for your dental care are submitted on the day treatment is completed. In the event your insurance carrier remits less than the estimated amount of the claim, for any reason inclusive of denied claims, the patient/responsible party, is financially responsible to pay the unpaid balance. Bills for any amount due will be sent to you upon receipt of remittance or explanation of benefits by your insurance company. Payment is due within 30 business days from the date the bill is mailed. If payment is not received by the noted due date, it will be considered PAST DUE and may be sent to collections. Any questions or arrangements pertaining to your bill must be addressed within this 30 day period to keep this account in our office.

Financial Responsibility Agreement

Michel Daccache Oral and Maxillofacial surgery is committed to providing the highest quality care services to our patients. In return, I agree to be financially responsible for payment of Michel Daccache Oral and Maxillofacial surgery services.

Initial:_____

I agree to give Michel Daccache Oral and Maxillofacial surgery complete and accurate insurance information for any primary/secondary insurance coverages. I understand that failure to supply complete and accurate information may result in denial of my claim or delay of insurance remittance. I agree to pay any balance remaining on my account after my insurance claim(s) are processed. **Initial:_____**

I understand my financial responsibilities as they may relate to my dental insurance plan, and understand that any insurance portion(s) not paid by my insurance company(s) are my financial responsibility. In the event of self-pay patients, non-insurance based treatment, I understand that I will be given a detailed treatment and fee estimate prior to any dental work being performed. I understand that I will be 100% financially responsible for the cost of such treatment.

Initial:_____

I understand that any invoice or receipt issued by Michel Daccache Oral and Maxillofacial surgery is a non-binding **estimate only**, and additional charges may apply depending upon actual amounts remitted by my insurance company for services rendered **Initial**:_____

I understand that there is a $50 **non-refundable** and **non-transferable** fee if I fail to give a 24 hour cancellation notice. If I reschedule my missed appointment the fee is due to prior to rescheduling.

Initial:_____

Please acknowledge your understanding of this notice and your willingness to comply with the above.

X_____ X_____

Responsible Party (Print name) **Responsible Party (Signature)**

We are able to send your prescriptions to your pharmacy electronically. Please provide the following information below:

Patient Name:

_____

Medical Allergies:

_____

Pharmacy Name:

_____

Pharmacy Address:

_____

_____

Phone Number:

_____

If under 18 years of age, Height: _____ Weight: _____

1701 West Charleston Blvd #520 Las Vegas, NV 89102 p: 702-750-9444 f:702-750-9442
4544 S Pecos Rd Las Vegas, NV 89121 p:702-436-0900 f:702-436-0636

MICHEL DACCACHE ORAL AND MAXILLOFACIAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____