RX History on Ga. Aware? Yes or No
Date Checked: _____
Patient Chart #_____

Health History Form

Title: (Mr., Mrs., Ms., Dr.) **Date:**_____
First Name:_____ **M.I:**_____ **Last Name:** _____ **Preferred Name:** _____
Date of Birth: _____ **Age:**_____ **Sex: M F** **SSN:** _____
Marital Status: Married Divorced Legally Separated Widowed Single
Address:_____
City:_____ **State:**_____ **Zip:**_____
Home phone: ( )_____ **Cell: ( )**_____ **Work: ( )** _____
Email Address: _____
Are you employed? Yes No - Full Part time - Where? _____
Student status: Yes No - Full Part time - School Name: _____
Primary Care Physician: _____**General Dentist:**_____
Pharmacy:_____
How did you hear about our office? (Circle One) Website Phonebook Sign Other: _____
Family/Friend: Who?_____

Legal Guardian's Information (for minor child only):

Name:_____ Date of Birth:_____Relationship:_____
Address:_____ City/State:_____ Zip: _____
Home Phone: ( )_____ Cell Phone: ( )_____

Do you have insurance? YES or NO

Primary Dental Insurance Information (if applicable)	**Policy Holder's Information**
Insurance Co.:_____	Name:_____
Address:_____	Relationship to Patient:_____
_____	Date of Birth:_____Sex: M or F
Phone: ( )_____	SSN:_____
Employer:_____	Address:_____
Group Name:_____	_____
Group Number:_____	Home Phone: ( )_____
ID:_____	Cell Phone: ( )_____
Claims Mailing Address:_____	Work: ( )_____ EXT:_____
_____	
Primary Medical Insurance Information (if applicable)	**Policy Holder's Information**
Insurance Co.:_____	Name:_____
Address:_____	Relationship to Patient:_____
_____	Date of Birth:_____Sex: M or F
Phone: ( )_____	SSN:_____
Employer:_____	Address:_____
Group Name:_____	_____
Group Number:_____	Home Phone: ( )_____
ID:_____	Cell Phone: ( )_____
Claims Mailing Address:_____	Work: ( )_____ EXT:_____
_____	

Reason for today's visit: _____

Are you currently under the care of a specialist? YES NO

If yes, for what condition(s):_____

Name of specialist(s): _____

Patient Name: _____ **Birthday:** _____

GENERAL HEALTH QUESTIONAIRE

(PLEASE CIRCLE YES OR NO) - DO YOU HAVE OR HAVE YOU EVER EXPERIENCED THE FOLLOWING:

Anemia/Thin Blood	**YES**	**NO**	**Heart Murmur**	**YES**	**NO**
Angina/Chest pain	**YES**	**NO**	**Hepatitis/Liver**	**YES**	**NO**
Arthritis	**YES**	**NO**	**High Blood Pressure**	**YES**	**NO**
Artificial Joint Replacement	**YES**	**NO**	**Immune Deficiency**	**YES**	**NO**
Asthma	**YES**	**NO**	**Kidney or Dialysis**	**YES**	**NO**
Atrial Fibrillation	**YES**	**NO**	**Lupus/Autoimmune**	**YES**	**NO**
Bleeding Issues	**YES**	**NO**	**Sleep Apnea/CPAP**	**YES**	**NO**
Bronchitis/Smoking History	**YES**	**NO**	**Osteoporosis**	**YES**	**NO**
Cancer	**YES**	**NO**	**Pain Management Clinic**	**YES**	**NO**
Convulsions/Seizures	**YES**	**NO**	**Rheumatic Fever**	**YES**	**NO**
Cough/Cold/sore throat	**YES**	**NO**	**Stomach Ulcer**	**YES**	**NO**
Diabetes	**YES**	**NO**	**Stroke/Weakness**	**YES**	**NO**
Emphysema	**YES**	**NO**	**Thyroid Issues**	**YES**	**NO**
Glaucoma	**YES**	**NO**	**TMJ Issues**	**YES**	**NO**
Heart Attack/Heart Surgery	**YES**	**NO**	**Tuberculosis/+PPD**	**YES**	**NO**
Cardiac Stent	**YES**	**NO**	**Gastric Reflux**	**YES**	**NO**
Radiation Therapy (Head/Neck)	**YES**	**NO**	**Sinus Issues/ Sinus Surgery/Polyps**	**YES**	**NO**
Do You Take Prescription Blood Thinner	**YES**	**NO**			
Positive COVID-19 History	**YES**	**NO (if answered yes what was date_____)**			

Any other medical problems not listed above: _____

_____

Are you <u>now using</u> or have you <u>ever used</u> drugs such as: (THIS IS CONFIDENTIAL AND WILL NOT HINDER TREATMENT)
Cocaine, Heroin, Methamphetamine, Others? YES NO
Marijuana? YES NO If yes how often? _____
Do you smoke/vape? YES NO If Yes, how much? _____
Are you a Drinker? YES NO If Yes, how often? _____

(PLEASE CIRCLE YES OR NO)- DO YOU HAVE ANY ALLERGIES OR SENSITIVITES TO THE FOLLOWING:

Aspirin	**YES**	**NO**	**Sulfa**	**YES**	**NO**
Codeine	**YES**	**NO**	**Latex**	**YES**	**NO**
Iodine	**YES**	**NO**	**Cephalosporin**	**YES**	**NO**
Penicillin	**YES**	**NO**	**Clindamycin**	**YES**	**NO**

Other: _____
Have you or anyone that you are directly related to ever had any unusual reactions to anesthesia or surgery? YES or NO
If YES, describe: _____

<u>WOMEN: CIRCLE YES OR NO</u>
Are you taking birth control pills? YES NO (Antibiotics may interfere with these medications)
Are you currently nursing? YES NO
Do you think you may be pregnant? YES NO Date of your last menstrual cycle:
Do you wish to consult your physician to rule out pregnancy before surgery? YES NO

Please list ALL previous surgeries and/or hospitalizations: (IF NONE, PLEASE PUT NONE) _____

_____

Please list all medications, pills, herbal medicines: (IF NONE, PLEASE PUT NONE) _____

_____

Would you like to discuss any other issues with the Doctor? YES or NO _____

_____

I certify that the above information is correct to the best of my knowledge:

_____ _____

Patient's Signature (Guardian's Signature if Patient is a Minor) **Date**

Beninato Oral Surgery
21 John Maddox Drive
Rome, GA. 30165
(706)-234-0718

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

- Home/Mobile Telephone: (_____)_____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only
- Work Telephone: (_____)_____
  - ❑ O.K. to leave message with detailed information
  - ❑ Leave message with call-back number only

- Written Communication
  - ❑ O.K. to mail to my home address

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

❑ Spouse
❑ Parent
❑ Child
❑ Other (specify): _____
❑ None

EMERGENCY CONTACT:

NAME: _____ **RELATIONSHIP:** _____

PHONE NUMBER: (_____)_____

_____ _____
Patient's Signature (Guardian's Signature if Patient is a Minor) Date

_____
Please Print **PATIENT'S** Name

Beninato Oral Surgery
21 John Maddox Drive
Rome, GA. 30165
(706)-234-0718

Appointment Cancellation and No-Show Policy

Thank you for trusting Dr. Beninato with your oral surgery needs. When you schedule an appointment with Beninato Oral Surgery we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

***** Effective January 1, 2021 any patient who fails to show for a **CONFIRMED** appointment or cancels ANY appointment at least by noon the day prior will be charged a "No Show/Broken Appointment" fee of $100.00.
***** The fee is charged to the patient, not the insurance company, and is due **BEFORE** the patient's next visit is scheduled. If a patient accumulates 2 no shows or cancelations within 12 months, in addition to this fee the patient will also be required to pay their portion of the surgery **BEFORE** another appointment is scheduled.
***** Late appointments will be determined on a case basis by Dr. Beninato and may be required to reschedule.

As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office as soon as possible.

You may contact Beninato Oral Surgery, 7 days a week at the number listed above. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the "Appointment Cancellation/No Show Policy", and agree to its terms. I have been given the opportunity to ask questions and all of my questions have been answered. I understand that if I have additional questions in the future, all I need to do is contact the office.

_____ _____
Patient's Signature (Guardian's Signature if Patient is a Minor) Date

_____
Please Print **PATIENT'S** Name

JOHN J. BENINATO
DDS, PC
ORAL AND MAXILLOFACIAL SURGERY
DENTAL IMPLANTS

21 John Maddox Drive * Rome, GA 30165
P: 706-234-0718 * F: 706-290-9577 *www.romegaoralsurgery.com

FINANCIAL POLICY

Thank you for choosing John J. Beninato DDS, PC Oral & Maxillofacial Surgery. We are committed to providing the highest quality care at a reasonable fee scale. In this era of rising healthcare expenses, we will make every effort to keep fees down. However, we will not sacrifice quality and patient care to reduce fees. To avoid misunderstandings, we ask you to **read** and **sign** our financial policy prior to treatment. A wide variety of services are available. Therefore, we do not have a uniform policy that covers all procedures and treatments.

- **You are responsible for your fees:** Patients or their legal guardian are responsible for all fees incurred during treatment and must pay for services rendered. We will file your insurance claim as a courtesy to our patients, but our relationship is with you and not your insurance company. You remain legally responsible for your balance.
- **Payment for service:** PAYMENT IS REQUIRED AT THE TIME OF SERVICE. If you are not covered by insurance, you must pay in full for all fees at the time service is rendered unless prior arrangements have been made in our office.
- **If you do not have insurance:** Payment in full is expected at the time service is provided or financing is available through the healthcare financing program, CareCredit.
- **If you have insurance:** As a valued service to you, we will investigate your insurance benefits, estimate your out-of-pocket fees and file claims on your behalf.
    - You must pay for estimated out-of-pocket expenses, such as estimated co-payments, deductibles, non-covered services or services requiring further review by your insurance carrier before treatment is initiated.
    - To determine the amount that might be paid by your dental insurance, we can file a written pre-treatment estimate to your carrier at your request. Most carriers require 4-6 weeks to complete this process, so treatment will be delayed. If you receive additional dental treatment before the scheduled procedure in our office or any other dental office, your estimate remaining benefits could be less or non-existent. Medical insurance carriers will not provide written pre-treatment estimates. They will only inform us if you have benefits and if the service might be covered.
    - An insurance estimate is not a guarantee that your insurance company will pay exactly as estimated. Your insurance company determines the final amount paid at the time the claim is processed.
    - Verification of benefits is not a guarantee of payment by the insurance company. Final determination is made by the time the claim is processed.
    - Payment in full is expected no longer than 90 days after your claim has been filed by us. Insurance payments are supposed to be made by insurance companies within 30 days of filing. However, if your insurance policy has not paid within 90 days, you may be asked to contact your insurance company to investigate your claim status. If your payment is not received within 90 days of filing or if your claim is denied, you will need to pay the balance in full at that time. The payment will be applied to an authorized credit card (see separate form) or may be paid by check. If your treatment plan fee is more than $2,500.00, you will be required to authorize a credit or debit card.
    - We will cooperate with your insurance company and exhaust all efforts to assist with processing your claim. Please do not submit additional claims or information to the insurance company unless specifically requested.

- **Dental implant surgery:** Insurance carriers provide limited coverage for dental implant and related procedures, such as bone grafting and CT scanning. A down payment of the fees must be made when scheduling implant procedures. The remaining fees will need to be paid at the time of implant surgery.
- **Patients with Medicare & Medicaid (public aid programs):** Dental procedures are not covered by Medicare. We are not Medicare nor Medicaid providers. If you have a Medicare supplemental plan, we will file that on your behalf but these may only provide limited coverage.
- **Minor patients:** The parent or guardian accompanying a minor is responsible for payment of services. Regardless of insurance coverage, patients age 18 and older are responsible for payment unless a parent accompanies them to the initial appointment and signs this agreement.

- **Divorce situations:** The parent bringing the child to the initial appointment is responsible for all fees incurred during treatment, regardless of who provides insurance coverage. Our office will not become involved in payment disputes between divorced parents.
- **Returned checks/Missed Appointments:** $30.00 will be applied for returned checks. A $100.00 fee will be applied for any missed or broken appointments not cancelled at least by noon the day prior. Temporary or post-dated checks are not accepted.

I have read the above, understand and agree to the above terms and conditions, and I agree to be responsible for total payment of my account:

_____

Patient's Signature (Guardian's Signature if Patient is a Minor) Date

I authorize my insurance benefits be paid directly to John J. Beninato D.D.S., P.C. Oral & Maxillofacial Surgery

_____

Patient's Signature (Guardian's Signature if Patient is a Minor) Date