

PATIENT INFORMATION

Date: _____

Mr. _____ Miss _____ Mrs. _____ Dr. _____ Name you would like to be called _____

Name: (First) _____ (Last) _____ (Initial) _____

Male Female Age: _____ Date of Birth: _____ Soc. Sec. # _____

Patient Address: _____ Employer: _____

City/State _____ Zip Code: _____ Driver's License # _____

Home Phone: _____ Work/Cell Phone: _____

General Dentist: _____ Referred By: _____

Student: Yes No If yes, where: _____

Emergency Contact: _____ Telephone Number: _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Method of Payment: Cash Check Credit Card Debit

RESPONSIBLE PARTY INFORMATION (Complete only if different from patient.)

Name: _____ Date of Birth: _____

Address: _____ Soc. Sec. #: _____

City/State _____ Zip Code: _____ Driver's License # _____

Home Phone: _____ Employer: _____ Work Phone: _____

Responsible Party Relationship to Patient: Spouse Parent Child Other

INSURANCE INFORMATION

We will gladly file your primary dental and medical insurance for you. After your primary insurance has paid, we will be happy to file any secondary insurance for you if your account has been paid in full. Please note you are responsible for any balance not paid by your insurance carrier.

In order for us to File your claims, we must make a copy of your insurance card.

Insured's Name: _____ Insured Date of Birth: _____

Address: _____ Insured Soc. Sec. #: _____

City/State _____ Zip Code: _____ Insured's Relation to Patient: _____

Insured's Employer: _____ Self Spouse Child Other

Employer Address: _____ Work Phone: _____

DENTAL INSURANCE:

Name of Carrier: _____

Address: _____

Group Number: _____ Insured I.D. # _____

MEDICAL INSURANCE:

Name of Carrier: _____

Address: _____

Group Number: _____ Insured I.D. #: _____

U P S T A T E

ORAL AND MAXILLOFACIAL SURGERY, P.A.

Laura Mills Summers, D.M.D.
James W. Strider, Jr., D.M.D.

280 North Grove Medical Park Drive • Spartanburg, SC 29303-4222
Phone: (864) 585-3318 • Fax: (864) 585-4800

www.scupstateoms.com

DIPLOMATES, AMERICAN BOARD OF
ORAL & MAXILLOFACIAL SURGERY

FELLOWS, AMERICAN ASSOCIATION OF
ORAL AND MAXILLOFACIAL SURGEONS

OUR FINANCIAL POLICY and INSURANCE INFORMATION

All patients must complete our Information and Insurance form before seeing the doctor. We accept Cash, Checks, or Visa, Mastercard, Discover, Amex, Care Credit. As a courtesy to our patients, we will gladly file your insurance for you. We are equipped to file your claims electronically which accelerates payment of your claim. The total charges for your care is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us correct insurance information and allow us to copy your insurance card. Your insurance is a contract between you and your insurance company. We are not a party of that contract.

By South Carolina law, your insurance company is required to respond to any claims submitted within 60 days. If your insurance company has not paid any outstanding portion of your bill within 60 days, the balance is expected to be paid in full by you at that time. We will send patients a monthly statement as a courtesy, regardless of pending insurance to keep patients informed of account activity.

Please be aware that some, or perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Please be aware that our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Many insurance companies will advise you that our fees are not usual, or customary. This is an arbitrary determination and may be a stall tactic to avoid reimbursing you for benefits under your insurance policy. Should you feel you have been treated unfairly by your insurance company, we recommend that you communicate with the South Carolina Insurance Commissioner's Office for assistance at 803-737-6160, or you may write them at S.C. Insurance Commissioner, P.O. Box 100105, Columbia, SC 29202.

Please be aware that some insurance carriers will deny receipt of your claim. We recommend that you follow-up with your insurance carrier within the next 30 days and advise us if there is a problem.

Please be aware that some insurance carriers will request additional information. . .such as dental records, x-rays, etc., which, in our opinion, unnecessarily delays payment. We respond to each request as quickly as time permits.

We will gladly provide you with a copy of your claim after it has been submitted to your insurance company. However, we will only re-file your claim for you one time without an additional charge to you.

Thank you for choosing us as your oral surgery provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Non-emergency treatment may be denied for patients who have an outstanding balance unless charges have been pre-authorized to a Visa, Mastercard, Discover, Amex, Care Credit, or payment by cash/check, is made before the treatment/service is performed by us.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____
Signature of Patient (Or Responsible Party)

Date: _____

UP STATE

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Patient: _____

Medical Physician: _____ Office Phone: _____

Date of Exam: _____

	YES	NO		YES	NO
1. Are you under medical treatment now? _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have or have you had any of the following?		
			High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
			Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
			Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including nonprescription medicine? Meds: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Angina	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you allergic to or have you had reactions to the following:	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetics (eg. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Aids or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Eggs, Soy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
7. Women only?			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/ Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Currently taking Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva) ..	<input type="checkbox"/>	<input type="checkbox"/>
			Blood Thinner (Plavix, Warfarin, Coumadin, Aspirin)	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>

SIGNATURE	<p>I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.</p>
<p>Signature of Patient or Parent if Minor X _____</p>	

Upstate Oral & Maxillofacial Surgery, PA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgment****

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

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