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. #: ____

UPSTATE
ORAL AND MAXILLOFACIAL SURGERY, P.A.

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

280 North Grove Medical Park Drive • Spartanburg, SC 29303
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 accepts 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 ____ Date: ______________________________

Signature of Patient (Or Responsible Party)

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FELLOWS, AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS

Patient: ____

Medical Physician:____________________________Office Phone: _________________ Date of Exam: ______________

	YES	NO
1. Are you under medical treatment now?	❒	❒
____		
____		
____		
2. Have you ever been hospitalized for any surgical operation or serious illness?	❒	❒
____		
____		
3. Are you taking any medication(s) including nonprescription medicine?	❒	❒
Meds: ____		
____		
____		
____		
4. Do you use tobacco?	❒	❒
5. Do you use alcohol?	❒	❒
6. Are you allergic to or have you had reactions to the following:	❒	❒
Local Anesthetics (eg. Novocaine)	❒	❒
Antibiotics	❒	❒
Sedatives	❒	❒
Iodine	❒	❒
Eggs, Soy	❒	❒
Aspirin	❒	❒
Other	❒	❒
7. Women only?		
Are you pregnant or think you may be pregnant?	❒	❒
Are you nursing?	❒	❒
Are you taking birth control pills?	❒	❒

8. Do you have or have you had any of the following?	YES	NO
High Blood Pressure?	❒	❒
Heart Attack	❒	❒
Heart Surgery	❒	❒
Valve Replacement	❒	❒
Rheumatic Fever	❒	❒
Swollen Ankles	❒	❒
Fainting / Seizures	❒	❒
Angina	❒	❒
Asthma	❒	❒
Low Blood Pressure	❒	❒
Epilepsy / Convulsions	❒	❒
Leukemia	❒	❒
Diabetes	❒	❒
Kidney Diseases	❒	❒
Aids or HIV Infection	❒	❒
Thyroid Problem	❒	❒
Heart Disease	❒	❒
Cardiac Pacemaker	❒	❒
Heart Murmur	❒	❒
Anemia	❒	❒
Emphysema	❒	❒
Cancer	❒	❒
Hepatitis/ Jaundice	❒	❒
Sexually Transmitted Disease	❒	❒
Stomach Troubles / Ulcers	❒	❒
Chest Pains	❒	❒
Easily Winded	❒	❒
Stroke	❒	❒
Tuberculosis	❒	❒
Radiation Therapy	❒	❒
Glaucoma	❒	❒
Liver Disease	❒	❒
Respiratory Problems	❒	❒
Currently taking Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva)	❒	❒
Blood Thinner (Plavix, Warfarin, Coumadin, Aspirin)	❒	❒
Other ___________________	❒	❒

SIGNATURE

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.

Signature of Patient or Parent if Minor X ____

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)

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