

RICHARD S. MAYO, D.D.S., F.A.C.O.M.S.

ORAL AND MAXILLOFACIAL SURGERY

We share your concern about the cost of quality dental and medical care. Our fees reflect the complexity and resources involved in completing our procedures. They are comparable to the usual and customary fees charged by like specialists in this area. We are committed to providing you with the best care possible. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- ◆ **ALL PATIENTS, REGARDLESS OF INSURANCE COVERAGE, ARE RESPONSIBLE FOR PAYMENT OF INITIAL EXAMINATION OR CONSULTATION FEES ON THE DAY OF THE APPOINTMENT.**
- ◆ **WE ACCEPT CASH, CHECK, VISA, MASTER CARD, AND DISCOVER.**
- ◆ **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.**

Insurance is a contract between you and your insurance company. While we will do our best to help you receive the maximum benefits, we will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" determinations, etc. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.** If your insurance company has not paid your claim **IN FULL** within 45 days, the balance becomes your responsibility, and a finance charge may accrue.

- All patients must complete our "Patient Information Form" and "Health History" before seeing the doctor.
- Due to the Health Insurance Portability & Accountability Act of 1996 (HIPPA) each patient will receive a "Notice of Privacy Practices".

**THANK YOU FOR UNDERSTANDING OUR POLICY.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.**

I have received and understand your *Notice of Privacy Practice*, which contains a complete description of the uses and disclosures of my health information.

I have read and agree to this policy.

I authorize release of any medical/dental information necessary to process my claim.

I authorize payment of my medical/dental benefits to Dr. Richard Mayo directly.

Patient or Guardian's Signature

Date

PATIENT'S NAME _____

PLEASE CHECK

YES NO

1. Who is your family physician? _____
If so, for what? _____

Are you under his treatment?

2. Have you had a complete physical within the past year?

3. Are you now or have you within the past year been taking any pills or medicine?

If so, what? _____

4. Do you have any allergies or are you sensitive to any drug or medicine?

Please specify: _____

5. Is there any family history of problems during anesthesia?

If so, what? _____

6. Do you bruise easily or bleed longer than normal for a cut or surgery?

If so, please elaborate _____

7. Have you had any of the following? Please check YES or NO

YES	NO	YES	NO	YES	NO	YES	NO				
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells or Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Positive
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint

8. Have you had any other serious illnesses or conditions requiring a physician's care or hospitalization?

If so, please list _____

9. Do you cough frequently? (repeatedly during the day)

10. Do you smoke? How many packs per day? _____

11. Do you require any extra pillows when you recline or sleep?

12. Have you ever had radiation or X-ray therapy?

13. Have you experienced any unfavorable reaction from a local or general anesthetic?

Please explain _____

14. Are you pregnant?

OB-GYN problems?

15. Do you take tranquilizers or other nerve medication?

16. Do you take recreational drugs?

17. Do you wear contact lenses?

18. What is your height? _____ and weight _____?

WOMEN NOTE: Antibiotics (such as penicillin, erythromycin, etc.) and some pain medications may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I AFFIRM THAT THE ABOVE MEDICAL HISTORY IS CORRECT. _____
Signature of patient or legal guardian Date

History Reviewed _____

History Reviewed _____

PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

NAME _____ SS# _____ BIRTHDATE _____
FIRST M.I. LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

SEX: MALE FEMALE MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF PATIENT IS STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

REFERRING DOCTOR _____ FAMILY DENTIST _____

IF NOT REFERRED BY DOCTOR, WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ SS# _____ BIRTHDATE _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS# _____

NAME OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP# _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

SIGNATURE