Welcome
Welcome
Welcome

# WELCOME TO OUR PRACTICE

## PATIENT INFORMATION

Date _____

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.( _____ ) _____ Cell.( _____ ) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME) Referred By _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.( _____ ) _____

Employer _____ Bus. Tel.( _____ ) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

## Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

(If self, skip to next section)

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.( _____ ) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.( _____ ) _____

## Spouse or other guarantor information (*if different from above*)

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. ( _____ ) _____ Employer _____ Bus. Tel.( _____ ) _____

## INSURANCE INFORMATION

1.IO

**Student:** ❑ Full Time ❑ Part Time ❑ Not School Info _____ (SCHOOL NAME) _____ (ADDRESS)

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____ (CITY) _____ (STATE) _____ (ZIP)

**Employed:** ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

## PRIMARY DENTAL INSURANCE COMPANY

❶

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____ ) _____ Plan _____

1.I1

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____ ) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____ ) _____ S.S. # _____

I.D. # _____

## PRIMARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____ ) _____ Plan _____

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____ ) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____ ) _____ S.S. # _____

I.D. # _____

## SECONDARY DENTAL INSURANCE COMPANY

❷

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____ ) _____ Plan _____

1.I1

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____ ) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____ ) _____ S.S. # _____

I.D. # _____

## SECONDARY MEDICAL INSURANCE COMPANY

**Employer** _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.( _____ ) _____ Plan _____

**Ins. Co. Name** _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel.( _____ ) _____

**Group #** _____ **Group Name** _____

**Insured Party** _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel.( _____ ) _____ S.S. # _____

I.D. # _____

## HEALTH HISTORY

**To our patients:** Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

| | | Yes | No |
|---|---|---|---|
| 99. | Are you in good health? ..... Height ____ Weight ____ | ❑ | ❑ |
| 100. | Have there been any changes in your general health in the past year? ..... | ❑ | ❑ |
| 101. | Are you under the care of a physician? ..... Date of last visit ____ | ❑ | ❑ |
| | *If so, for what are you being treated?* ____ | | |
| 102. | Have you had any illness, operation or been hospitalized in the past five years? ..... | ❑ | ❑ |
| | *If so, describe* ____ | | |
| 103. | Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ..... *If so, describe where* ____ | ❑ | ❑ |
| 104. | Do you have a prosthetic joint/implant? *If so, describe where* ____ | ❑ | ❑ |
| 105. | Have you had a heart valve replacement or vascular graft? ..... | ❑ | ❑ |

| | HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . . | Yes | No | NOTES |
|---|---|---|---|---|
| 106 | Rheumatic fever? | | | |
| 107 | Damaged heart valves / mitral valve prolapse? | | | |
| 108 | Heart murmur? | | | |
| 109 | High blood pressure? | | | |
| 110 | Low blood pressure? | | | |
| 111 | Chest pain / angina? | | | |
| 112 | Heart attack(s)? | | | |
| 113 | Irregular heart beat? | | | |
| 114 | Cardiac pacemaker? | | | |
| 115 | Heart surgery? | | | |
| 116 | Bronchitis, chronic cough? | | | |
| 117 | Asthma? | | | |
| 118 | Hay fever / sinus problems? | | | |
| 119 | Snoring / sleep apnea? | | | |
| 120 | Difficult breathing / other lung trouble? | | | |
| 121 | Tuberculosis? | | | |
| 122 | Emphysema? | | | |
| 123 | Do you smoke? | | | |
| 124 | Do you use chewing tobacco? | | | |
| 125 | Blood transfusion? | | | |
| 126 | Blood disorder such as anemia? | | | |
| 127 | Bruise easily? | | | |
| 128 | Bleeding tendency / abnormal bleed? | | | |
| 129 | Hepatitis, jaundice, or liver disease? | | | |
| 130 | Infectious mononucleosis? | | | |
| 131 | Gallbladder trouble? | | | |
| 132 | Fainting spells? | | | |
| 133 | Convulsions / epilepsy? | | | |

| | HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . . | Yes | No | NOTES |
|---|---|---|---|---|
| 134 | Stroke? | | | |
| 135 | Thyroid trouble? | | | |
| 136 | Diabetes? | | | |
| 137 | Low blood sugar? | | | |
| 138 | Kidney trouble? | | | |
| 139 | Are you on dialysis? | | | |
| 140 | Swollen ankles, arthritis or joint disease? | | | |
| 141 | Stomach ulcers? | | | |
| 142 | Contagious diseases? | | | |
| 143 | Sexually transmitted diseases? | | | |
| 144 | Are you immunosuppressed? possibly from transplant surgery, etc. | | | |
| 145 | Problems with the immune system? possibly from medication / surgery, etc. | | | |
| 146 | Delay in healing? | | | |
| 147 | A tumor or growth? | | | |
| 148 | Radiation therapy / chemotherapy? | | | |
| 149 | Chronic fatigue / night sweats? | | | |
| 150 | Are you on a diet? | | | |
| 151 | A history of drug abuse? | | | |
| 152 | A history of alcohol abuse? | | | |
| 153 | Contact lenses? | | | |
| 154 | Eye disease / glaucoma? | | | |
| 155 | Mental health problems? | | | |
| 156 | A removable dental appliance? | | | |
| 157 | Pain and clicking of jaws when eating? | | | |
| 158 | Malignant hyperthermia? | | | |
| 159 | **IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours? | | | |
| 160 | Who is driving you home? | | | |

## *MEDICATION – Are you now taking or have you taken. . .*

| | | Yes | No | NOTES |
|---|---|---|---|---|
| 201 | Any kind of medication, drug, pills? | | | |
| 202 | Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)? | | | |
| 203 | Have you ever taken diet pills? | | | |
| 204 | Any natural product, herbal supplement or homeopathic remedy? | | | |
| 205 | Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)? | | | |
| 206 | Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list: | | | |
| 207 | Please list any medications you are currently taking: | | | |

## *ALLERGIES – Are you allergic to, or had a reaction to. . .*

| | | Yes | No | NOTES |
|---|---|---|---|---|
| 208 | Local anesthetic (numbing med.)? | | | |
| 209 | Penicillin? | | | |
| 210 | Other antibiotics? | | | |
| 211 | Sulfa Drugs? | | | |
| 212 | Sodium pentothal, Valium, or other tranquilizers? | | | |
| 213 | Aspirin? | | | |
| 214 | Codeine or other narcotics? | | | |
| 215 | Other medications? | | | |
| 216 | Latex? | | | |
| 217 | Soy? | | | |
| 218 | Eggs / Yolk? | | | |
| 219 | Sulfites? | | | |
| 220 | Please list any allergies other than drug allergies: | | | |

**Is there any condition concerning your health that the Doctor should be told about?** ❑ **Yes** ❑ **No** ***(if so, describe)***

**Do you wish to speak to the doctor privately about anything?**

❑ **Yes** ❑ **No**

Is there a **FAMILY HISTORY** of:

301 **Cancer:** ❑ Yes ❑ No
302 **Diabetes:** ❑ Yes ❑ No
303 **Heart Disease:** ❑ Yes ❑ No
304 **Anesthetic Problems:** ❑ Yes ❑ No

**IN CASE OF EMERGENCY, CONTACT:**

Name _____

Home Tel.( _____ ) _____

Bus. Tel.( _____ ) _____

**IS THIS VISIT RELATED TO AN ACCIDENT?** **Automobile:** ❑ Yes ❑ No
**Work Related:** ❑ Yes ❑ No
**Other:** ❑ Yes ❑ No

**Date of Injury** _____

Insurance company handling this claim _____

Claim number _____

Name of Attorney / Adjustor _____

Telephone Number (_____) _____

**THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.**

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

***Women Note:*** *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

**I certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**Signature of patient:** *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

## FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

**Signature of patient:** *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

**Signature of patient:** *(Parent or Guardian if minor)* X **Date:** X

## AUTHORIZATION

**I authorize** my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X **Date** X **Signature of patient** *(Parent or Guardian if minor)*

**Witness:** X

**Doctor:** X

**I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.** I have been given the opportunity to ask any questions I may have regarding this Notice.

**Signature of patient:** *(Parent or Guardian if minor)* X **Date:** X

TRI VALLEY ORAL SURGERY
and Dental Implants
Pain-Free, Worry-Free, Stress-Free Oral Surgery

**Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery.**
**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**With my consent, Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to , Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. Notice of Privacy Practices for more complete descriptions of such uses and disclosures.**

**I have the right to review the Notice of Privacy Practices prior to signing this consent. , Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tri Valley Oral Surgery, 5401 Orris Canyon Road, Suite 210, San Ramon Ca 94583**

**With my consent, Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.**

**With my consent, Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment cards, insurance items, healthcare forms, and patient statements as long as they are addressed to the individual or marked personal and confidential.**

**I have the right to request that, Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.**

**By signing this form, I am consenting to, Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request. If I do not sign this consent, Tri Valley Oral Surgery. may decline to provide treatment to me. I am consenting to communications via email, text or phone.**

_____ _____ _____
**Signature of Patient or Legal guardian** **Printed Name of Patient or Legal guardian** **Date**

_____
**Relationship to Patient**

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES**
**By signing this authorization, I authorize Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. to use and/ or disclose certain protected health information about me to or for the party or parties listed below.**
**This authorization permits TVOMS to use or disclose to: _____**

**When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Anthony J. Rega, DDS, Inc dba Tri Valley Oral Surgery. has noted in reliance upon this authorization. My written revocation must be submitted to Tri Valley Oral Surgery, 5401 Norris Canyon Road, Suite 210, San Ramon Ca 94583**

**_**

_____ _____ _____
**Signature of Patient or Legal guardian** **Printed Name of Patient or Legal guardian** **Date**

_____
**Relationship to Patient**

# TRI VALLEY ORAL SURGERY
## and Dental Implants

Pain-Free, Worry-Free, Stress-Free Oral Surgery

**Patients are required to pay in full the day of service. Cash, Visa, MasterCard, Discover, American Express or Care Credit are accepted forms of payment. Please note we do not accept nor participate with any DMO/HMO insurance plans, prepay plans, Medicaid or Medi-Cal/Denti-Cal plans.**

I understand that Dr. Anthony J. Rega begins treatment with a consultation. The Doctor will need an x-ray, imagery, and/or other aids in order to recommend me the necessary procedures and services involved in the treatment. I acknowledge that it is the Doctor's standard of care for me to have a consultation first before scheduling the surgery. I understand and acknowledge that the office cannot inform me if I am eligible for the initial visit as frequency limitations may apply to these services and my dental insurance does not guarantee payment.

I understand that I am fully responsible for the payment of all costs associated with the procedure(s) and service(s) performed by the doctor and the team. I understand that my dental insurance company does not guarantee payment and any portion not covered by the insurance will be my responsibility. I acknowledge that any insurance coverage that I have will be based on a contract between my doctor, the insurance company, and me, the policy-holder, and/or my employer. Since the insurance may not cover 100%, I am required to make a copayment of 20% or more depending on my benefits and the amount I have available. Should my insurance company pay the full amount, I will be reimbursed, via check, for the co-payment I paid at the office. I understand that I am also responsible for all fees even if I have dual coverage after both insurances have paid or denied payment due to "Non-Duplication Policy." Therefore, I understand and acknowledge that I am liable for all fees not paid or declined by the insurance company (even after initially approving the services). As a courtesy to the patient, the doctor's team will bill my insurance company on the date of service. If for any reasons the insurance denies payment, I will be responsible for the remaining balance, which will be billed to me after 30 days from the service date

I hereby authorize insurance payment directly to the treating Doctor. If I wish to have the insurance payment assigned to me, I will pay the full amount of treatment to the Doctor on the day of surgery. I understand that I am financially responsible for all charges not covered by my insurance company.

By California Law, all minors MUST be accompanied by a parent/legal guardian for ALL appointments.

## ADDITIONAL TERMS

- Surgery appointments that are canceled with less than 72 business hours' notice are subject to a $200 cancellation fee. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- Consultation appointments that are canceled with less than 72 business hours' notice are subject to a $50 cancellation fee. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- All sedation patients whose designated driver and vehicle leaves the property will be charged an additional anesthesia monitoring fee of $100 per 30 min increment. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- Any check that is returned by a bank for Non-Sufficient Funds are subject to a minimum $40 processing charge.
- Any account that is greater than 90 days Past Due will be turned over to our Collection Agency, and due to the administrative charges, you will be subject, in addition, to a collection cost of 40% of the account balance. You may also be responsible for any court costs and reasonable attorney fees. Once your account is sent to collections, you cannot be treated in this office until that balance is $0.

I consent to be contacted by the Doctor, a representative of the office, or a collection agency (or agent) for any unpaid balance by phone, email or mail at any phone number or address that I provided the office or by facsimile, phone number (cell phone or landline), or email.

**ESTIMATED fees are guaranteed for 45 days. If you are unsure of the fee for service, it is your responsibility to confirm the fee prior to the procedure with the front desk staff.**

**I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF TVOS**

Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date:_____