IMPACT
ORAL SURGERY

Patient Information

Patient Name: _____

Nickname: _____ Male Female

DOB: _____/_____/_____ SSN: ____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____Cell: _____

Email: _____

Status: ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Information

Name: _____

Relation to patient: _____ Male Female

DOB: _____/_____/_____ SSN: ____ - _____ - ____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____Cell: _____

Email: _____

Employer _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Emergency Contact Name _____ Relationship _____ Phone_____

Dental Insurance Information

Primary Dental

Group ID: _____ Phone #: _____

Insurance Company: _____

Employer Name: _____

Subscriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Subscriber ID: _____ DOB: ___/___/____

Secondary Dental

Group ID: _____ Phone #: _____

Insurance Company: _____

Employer Name: _____

Subscriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Subscriber ID: _____ DOB: ___/___/___

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Medical Insurance Information

Group ID: _____ Phone #: _____Insurance Company: _____

Employer Name: _____Subscriber Name: _____

Address: _____City: _____ State: _____ Zip: _____

Relationship to patient: _____Subscriber ID: _____ DOB: ___/___/___

Current Dental Information

Referred by: _____

Dentist: _____ Date of last Dental Visit: _____

Orthodontist: _____ Date of last Ortho Visit: _____

Please have your driver's license and insurance card available for us to make a copy for your records.

I hereby authorize payment of medical/dental benefits to Rock Dental Brands for services rendered and agree that the entire bill is my responsibility, regardless of what my insurance coverage may be. Once my dentist obtained my one-time authorization, he may submit and later claim on an assigned or unassigned basis without obtaining any additional signature.

Payment is due the day services are rendered.

_____ _____

Patient/Legal Guardian Signature **Date**

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HEALTH QUESTIONNAIRE

Patient Name _____

Please mark all that apply

1. CARDIOVASCULAR DISEASE

- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Arteriosclerosis
- ☐ Heart Attack
- ☐ Heart Bypass Surgery
- ☐ Prosthetic Heart Valves
- ☐ Congenital Heart Malformations
- ☐ Hypertrophic Cardiomyopathy
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Bacterial Endocarditis
- ☐ Heart Stents or Shunts
- ☐ Osteoporosis
- ☐ Other _____

2. OTHER

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Angina / Chest Pain
- ☐ Arthritis or Rheumatism
- ☐ Asthma
- ☐ Autoimmune Disease / Lupus
- ☐ Blood transfusion since 1980?
- ☐ Cocaine use
- ☐ Cancer: Radiation / Chemotherapy
- ☐ Diabetes, taking insulin?
  Insulin name: _____
- ☐ Emphysema / Bronchitis
- ☐ Other Respiratory Issues/Easily winded
- ☐ Epilepsy / Seizure
- ☐ Fainting
- ☐ Frequently Tired
- ☐ Hay Fever
- ☐ Hepatitis: A B C
- ☐ Irregular Heartbeat
- ☐ Jaundice, liver disease
- ☐ Joint replacements? _____
- ☐ Kidney Problems
- ☐ Leukemia Type: _____
- ☐ Organ Transplant
- ☐ Pacemaker / Implanted Defibrillator
- ☐ Pregnant? How many months? _____
  - ☐ Planning to nurse?
- ☐ Psychiatric Treatment
- ☐ Sinus trouble
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Venereal Disease or AIDS virus
- ☐ Other

_____

_____

_____

_____

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3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Local Anesthetic
- ☐ Penicillin / Antibiotics
- ☐ Sulfa Drugs
- ☐ Other Medication Allergies:

_____

4. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

- ☐ Antibiotics
  Name of Antibiotic: _____
  Date Started: _____
- ☐ Antihistamines
- ☐ Appetite Suppressants
- ☐ Aspirin
- ☐ Cortisone
- ☐ Digitalis
- ☐ Heart Disease Medications
- ☐ High Blood Pressure
- ☐ Osteoporosis Medications
- ☐ Sulfa Drugs
- ☐ Tranquilizers
- ☐ Vitamins and/or Herbals

MEDICATION LIST:

List any other medications you are taking currently:

_____

_____

_____

_____

_____

_____

5. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?
Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefos, Zometa?

_____

_____

_____

6. HAVE YOU HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENTS?

_____

_____

_____

7. HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS IN THE PAST?

_____

_____

_____

_____

_____

_____ _____

Patient/Legal Guardian Signature **Date**

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OFFICE FINANCIAL POLICY

Payment is due in full at the time services are rendered. We will give you an estimated percentage your insurance will not cover at the time of service. If for any reason your insurance company should pay less than the estimated amount, the remaining balance will be your responsibility.

If you are not insured, payment is due the day services are rendered. We will require the full amount unpaid by insurance on the day services are rendered and we will bill your insurance company for the difference. Our policy is to allow a 30-day grace period from the date of services rendered for your insurance company to pay the difference.

Once your account reaches 30 days past due the balance becomes your responsibility and is due immediately. If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 90 days following your office visit, we may refer your account to our collection agency. Your account could be reported to the credit bureau.

Services provided by others (laboratories, etc.) outside of this practice are not part of the treatment fee and are your responsibility

PAYMENT TYPES | We accept cash, check, Visa, MasterCard, Discover and American Express as payment in our office. We charge $30.00 on all returned checks.

CARE CREDIT | Care Credit is a third-party dental/medical lender. We offer this as a payment plan option and can assist you with this application if you so choose.

By signing below, I hereby consent to the taking of x-rays, photographs, and other necessary records before, during and after treatment and to the use of the same by this practice for any reasonable purpose.

By signing below, I authorize the release to my insurance company or companies of any information including the diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

You agree, for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that Rock Dental Brands or affiliated collection agencies may contact me as described above.

_____ _____

Signature of Patient/Parent/Guardian Date

PHOTO AND VIDEO RELEASE

I hereby grant Rock Family Dental the right and unrestricted permission to use photos/videos taken of me (or my child), or in which I (or my child) may be included with others, and to use, reuse, publish, and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising, and trade, or any other purpose whatsoever without restriction.

_____ _____

Signature of Patient/Parent/Guardian Date

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APPOINTMENT POLICY – SURGERY SCHEDULING

Please be advised that when a surgery is scheduled for you that includes intravenous anesthesia (IV), we are reserving a time slot specifically for you, as well as for a Nurse Anesthetist. We must remit payment to the Nurse Anesthetist regardless of changes you may need to make to your surgery schedule. If you are not able to keep your originally scheduled appointment, you may be charged a $250 change fee to cover this expense. Please note, failure to keep the original appointment could result in a longer wait for a new surgery date. We are happy to reschedule, if necessary, but we require a minimum of 48-hours' notice.

If the patient is a minor, I understand that a legal guardian must be present at the new patient appointment and all treatment appointments. Any person bringing the patient to an appointment must be added to the patient's HIPAA form by the legal guardian prior to the appointment.

_____ _____

Signature of Patient/Parent/Guardian Date

TEXT AND EMAIL POLICY

Rock Dental Brands can email and/or text your appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Communication Preference (Please Circle One) Email Text

_____ _____

Signature of Patient/Parent/Guardian Date

CONSENT TO RECEIVE TREATMENT

Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for a complete recital of any possible complications.

_____ _____

Signature of Patient/Parent/Guardian Date

NOTICE OF PRIVACY POLICY

We care about your privacy and the privacy of your personal health information. By law, we are required to maintain your privacy, and to give you notice of our privacy policies and practices, if requested. Our Privacy Policy is displayed in our offices, can be viewed on our website, and a printed copy is available upon request.

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Please list below any person who can receive PHI (Protected Health Information) on this patient.

Name	Relationship	Treatment Info	Ledger
_____	_____	Yes No	Yes No
_____	_____	Yes No	Yes No

_____ _____
Signature of Patient/Parent/Guardian Date