ALABAMA ORAL & FACIAL SURGERY

www.alabamaoralsurgery.com

HENRY E. MCKAY, III DDS   CHRISTOPHER M. ROTHMAN, DDS   WALTER WILSON, DMD, MD

PATIENT INFORMATION____DATE________________

Name: ____ Preferred First Name: ________________

Patients Address: ____City: ______________________State: ____Zip: ___________

Date of Birth ____/______/_______Home#: (____) ______________Cell #: (____) _______________ Work#:(___) _______________

SS#______/_____/_______ SEX: _ M or _F_ Marital Status: _M S D W_Email Address: ____________________________________

Employer Name & Address: ________________________________ City: _____________________ State: ____Zip: ____________

REFERRING INFORMATION____

Referring Dentist: ________________ Internet: _____Friend: _____Insurance Website: _________ Other: _______________________

INSURANCE INFORMATION____

Dental Insurance: _______________________________ Policy Holders Name: ____
Policy Holder's SS#: _________/________/________ DOB: _______/________/________ Employer: ____________________________
Member ID/Contract#: ____________________________ Plan/Group#: ___________

Secondary Dental: _______________________________Policy Holders Name: ____
Policy Holder's SS# __________/_________/_________ DOB: _______/________/_______ Employer: ___________________________
Member ID/Contract#: ____________________________Plan/ Group#: ____________

Medical Insurance: ______________________________ Policy Holders Name: ____
Policy Holder's SS#: __________/_________/__________ DOB: ______/_______/______Employer: ___________________________
Member ID/Contract#: ________________________________Plan/Group#: ___________

Secondary Medical: ______________________________Policy Holders Name: ____
Policy Holder's SS#: _________/_________/__________DOB: _______/_______/_______Employer: ___________________________
Member ID/Contract#: ________________________________Plan/Group#: ___________

EMERGENCY CONTACT INFORMATION____

Name: ______________________________Email address: ___________________________________
Address: ____
Relationship to patient: _________________Home#: ____________________Cell#: ________________
Medical information can be discussed with: _______________________relationship: _______________

DRIVER'S INFORMATION/PERSON RESPONSIBLE DRIVING YOU HOME FROM SURGERY_____________

Driver's name_____________________/Relation______________/Cell #_____________DOB: ___/___/___

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR DISCUSS ANY MEDICAL INFORMATION TO:

____

AUTHORIZATION INFORMATION____

I authorize the Doctor/Staff to perform oral surgery and or examination for the purpose of treatment. I also, authorize the taking of 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. Furthermore, 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 or legal guardian X____

PATIENT NAME____DATE ___________________

ARE YOU IN A PAIN MANAGEMENT PROGRAM: Yes: ___No: ___ ARE YOU PREGNANT: Yes: _____ No: _____

List any drug allergies: ____
Food allergies: ____

Latex Allergy: Yes____ No_____ Egg allergy: Yes____ No ______ Tobacco User: Yes_____ No_______

Are you taking any bone building medications such as FOSAMAX, BONIVA, ACTONEL, ETC? LIST____________________
Are you taking any blood thinners such as COUMADIN, PLAVIX, ASPIRIN, ETC? LIST________________________________

Have you ever had radiation treatment for cancer to the head or neck? Yes ______No _______
If yes, please list treating doctor's name and phone#: ____

PLEASE PROVIDE US WITH YOUR PHARMACY NAME & NUMBER: ____

MEDICAL HISTORY/PLEASE CHECK IF ANY APPLY TO YOU____

____ALZHEIMER
____ASTHMA
____BLEEDING PROBLEMS
____CANCER, TUMOR /TYPE________
____COLITIS
____DIABETES
____EMPHYSEMA
____EPILEPSY/SEIZURE DISORDER
____FAINTING SPELLS
____HEART ATTACK
____HEART DISEASE
____HEART MURMUR
____HEPATITIS ____A____B____C
____HIV POSITIVE
____HIGH BLOOD PRESSURE
____LOW BLOOD PRESSURE
____LIVER DISEASE
____MITRAL VALVE PROLAPSE
____NERVOUS DISORDER
____PROSTHETIC HEART VALVE
____PROSTHETIC (ARTIFICIAL)JOINT REPLACEMENT
____RHEUMATIC FEVER
____SLEEP APNEA
____STEROID THERAPY
____STROKE
____THYROID DISORDERS
____TUBERCULOSIS
____OTHER___________________________________

Please list current medications: ________________
____
____
____
____

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIREIS 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. PATIENTS/OR LEGAL GUARDIAN SIGNATURE__________________________________DATE: __________________

ARE YOU RECEIVING GENERAL ANESTHESIA TODAY? YES _____NO_____
IF YES, HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE LAST SIX HOURS? YES _____NO _____
HAVE YOU HAD SURGERY IN THE LAST 6 MONTHS THAT REQUIRED GENERAL ANESTHESIA? YES ____NO____
PLEASE LIST ANY AND ALL SURGERIES: ____
PATIENTS RECEIVING GENERAL ANESTHESIA MAY NOT BE DROPPED OFF AND DRIVERS AND THE VEHICLES MUST REMAIN AT THE OFFICE AT ALL TIMES.

Medical Information Release Form
(***HIPAA Release Form***)

Name: ____________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records. examination rendered to me and claimed information. This information may be released, to:

[ ] Spouse____

[ ] Child(ren)_______________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:__________________
If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] or email you @: ____

[ ] By checking signifies that you received/read a copy of our Notice of Privacy Practices.

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: _______________________________________ Date: ____/____/_____
Patient/Guardian

Printed name of Patient/Guardian: ____

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We provide this form to comply with the Health Insurance Portability and Account Act of 1996 (HIPAA).

revised 02/28/2023

CHRISTOPHER M. ROTHMAN, DDS HENRY E. MCKAY, DDS WALTER WILSON, DMD, MD

CERTIFICATE OF DRIVER

PATIENT RECEIVING GENERAL ANESTHESIA (IV SEDATION) ARE
ARE REQUIRED TO HAVE SOMEONE IN THE BUILDING
AND TO DRIVE THEM HOME.

PATIENTS NAME: ____

DRIVERS NAME AND CELL NUMBER: ____

DATE OF SURGERY: ____

RESPONSIBILITIES FOR PATIENT'S DRIVER

Thank you for allowing us to care for your family member/friend today. We strive to give our patients the best care possible in an efficient manner. Here is a list of responsibilities that will need to be followed while the patient is being sedated for surgery:

- Remain in the building or on the premises during the patient's procedure. If you need to go to your car, please inform someone, and leave your cell number at the desk so you can be reach if needed. It is important to be available so the doctor can speak to you after surgery.
- Please collect all valuables (cell phone, purse, wallet, keys, or any other personal items).
- Obtain and read after-care instructions and any prescriptions that are given.
- Patient pick-up is in the back of our building, and you will be informed when to move your car. Please remain in your car and we will bring the patient out after the duration of recovery. At that time, the doctor will come out to speak with you and will answer any questions.

Many of our procedures are approximately 45-75 minutes. It is imperative that you do not leave the premises while the patient is under anesthesia. Any driver who is not available when the procedure is finished will have a $75 fee added to the patient's record. We cannot have patients unattended after recovery.

Thank you in advance for helping us provide exceptional care for our patients.

Patient signature: ____ Date: ________________

2290 Valleydale Road, Birmingham, AL 35244
Office #: 205-682-1099
Fax #: 205-403-7383

74 Plaza Drive, Suite 2E, Pell City, AL 35125
Office #: 205-338-6688
Fax #: 205-338-8818

Revised 5/3/2022

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash, debit cards, and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service. The practice does not accept payment via personal check. **Please note that payments made by credit card will incur a 3% surcharge.**

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid for by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. To bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at the time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Private pay/uninsured patients: (i) you must pay in full at time of service, and (ii) you hereby acknowledge receipt of a Good Faith Estimate as required by 45 C.F.R. §149.610 by signing below.

3. BILLING AND COLLECTION.

- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to pay said fees, including all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the practice, and anyone contacting you on our behalf, may communicate with you in any manner, including using an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

______________________________	____/____/______
Patient Name	Patient DOB
______________________________	______________________
Patient or Responsible Party Signature	Date
______________________________	______________________
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)

(Version 08.2024)