



# Triangle Oral & Maxillofacial Surgery

## David M. Lambert, DDS, PA

Patient's Name \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employed by: \_\_\_\_\_ Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_

Drivers License No: \_\_\_\_\_ Social Security No: \_\_\_\_\_ Email: \_\_\_\_\_

Parent or Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employed by: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_

In case of emergency contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How do you plan to pay: cash/check: \_\_\_\_\_ CC: \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

Dental Insurance Co: \_\_\_\_\_ PolicyNo: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_ PolicyNo: \_\_\_\_\_

PERSON RESPONSIBLE FOR FEE: Patient \_\_\_\_\_ Parent \_\_\_\_\_ Spouse \_\_\_\_\_ Other(Name) \_\_\_\_\_

**If we are submitting insurance in lieu of payment in full, we request that you place a major credit card on file.**

### INSURANCE AND FEES

In order to establish optimal relations with out patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES FOR SERVICES NOT COVERED BY INSURANCE. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, CHECKS, AND CASH. Your signature below indicates that you understand and accept this policy. Also, your signature authorizes Triangle Oral and Maxillofacial Surgery (TOMS) to release such medical and/or dental information to process your insurance claim (if any), and also to share your medical/dental information with other authorized health care practitioners.

I hereby authorize TOMS to furnish my insurance company all information, which said company, may request concerning my present illness or injury. I hereby assign to TOMS all sums payable to me from the amount of money to which I am entitled for medical and or surgical expenses. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE. I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

The fee for your treatment is determined by the complexity of your case. It is our policy that all fees are paid on the day of surgery. PLEASE BE ADVISED TOMS RESERVES THE RIGHT, AT THEIR DISCRETION, TO MAKE CHARGES FOR TIME SPENT DIRECTLY OR INDIRECTLY IN THE AUTHORIZED PURSUIT OF YOUR CARE. ANY FEE OR PORTION OF FEE UNPAID 30 DAYS AFTER COMPLETION OF SURGERY IS SUBJECT TO A LATE FEE OF 1.5% PER MONTH (18% PER ANNUM), OR \$10 PER MONTH, WHICH EVER IS GREATER. SHOULD LEGAL ACTION BE REQUIRED TO SECURE PAYMENT, YOU WILL BE CHARGED A REASONABLE ATTORNEY'S FEE OF 15% OF ANY AMOUNT OUTSTANDING AS WELL AS BEING CHARGED FOR ANY COURT FEES AND INTEREST.

**Please note**, we are **NOT** a participating provider for Medicare or Medicaid.

Should your account become past due more than 45 days, or if dental insurance benefits are denied in lieu of medical benefit determination at any time, account charges will become due and payable in full. I authorize the unpaid balance to be charged to my major credit card as listed below:

Visa

MasterCard

American Express

\_\_\_\_\_  
CARD #

\_\_\_\_\_  
EXP. DATE

\_\_\_\_\_  
NAME AS IT APPEARS ON CARD

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

### CHARGES FOR CANCELLATION OF APPOINTMENTS AND SURGERIES

If for any reason you fail to show for a scheduled appointment or surgery, your account will be charged a "broken appointment fee" of 50% for the time or procedure scheduled unless you provide written notice to this office 48 hours in advance of the scheduled appointment or surgery. This fee will be reduced to 25% if you reschedule your appointment within 30 days of the broken appointment. I also understand my appointment may be cancelled if I am 15 minutes or more late for any appointment.

I have read the above statements, understand them, and agree to the terms as stated.

\_\_\_\_\_  
SIGNED PATIENT OR PARENT IF MINOR

\_\_\_\_\_  
DATE

OVER

## Medical and Health History Questionnaire

Who referred you to this office? \_\_\_\_\_

The name and phone number of my physician is \_\_\_\_\_

The name and phone number of my dentist is \_\_\_\_\_

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

<b>Have you ever:</b>	<b>YES</b>	<b>NO</b>	<b>Do you have or have you ever had any of the following:</b>	<b>YES</b>	<b>NO</b>
Had a serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders/epilepsy/convulsions?	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Had a surgery or an operation in the past?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient ischemic attacks (TIA's)?	<input type="checkbox"/>	<input type="checkbox"/>
Received doctor's care in the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Mental health problems, psychiatric disorders, or panic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Had excessive bleeding after a surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Had a blood transfusion? If so when?	<input type="checkbox"/>	<input type="checkbox"/>	Facial trauma?	<input type="checkbox"/>	<input type="checkbox"/>
Had periods of unconsciousness or fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	Sinus or nasal problems?	<input type="checkbox"/>	<input type="checkbox"/>
Had a problem with local or general anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever?	<input type="checkbox"/>	<input type="checkbox"/>
Been immunosuppressed or have problems of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>	TMJ problems (pain near the ear, clicking or popping of the jaw joint, difficulty opening the mouth)?	<input type="checkbox"/>	<input type="checkbox"/>
Been treated for an alcohol or drug usage problem?	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems, cardiovascular disease, angina or chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you:</b>			Blood pressure problems (high or low)?	<input type="checkbox"/>	<input type="checkbox"/>
Presently wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to latex or rubber products or tape materials?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Breast Feeding?	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever or rheumatic heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve replacements?	<input type="checkbox"/>	<input type="checkbox"/>
Please list drug allergies: _____			Congenital heart defect?	<input type="checkbox"/>	<input type="checkbox"/>
Any other allergies? _____			Asthma/Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
Taking or have you taken prescription medications or drugs for weight loss?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
What medications (including non-prescription) are you currently taking? _____			Stomach ulcers, gastritis, acid reflux, or hyperacidity?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Colitis, diverticulitis or Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>
What herbal medications are you taking? _____			Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Thyroid disease?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Spleen removal?	<input type="checkbox"/>	<input type="checkbox"/>
_____			HIV / AIDS?	<input type="checkbox"/>	<input type="checkbox"/>
_____			A blood disorder (i.e., white or red blood cell, or platelet abnormality)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently smoke or chew tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or clotting problems?	<input type="checkbox"/>	<input type="checkbox"/>
Did you smoke or chew tobacco products in the past?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Hip or knee replacements?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Cancer (now or in the past)?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Radiation therapy or x-ray treatments for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Cortisone or steroid therapy?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Implants, transplants, or synthetic grafts placed anywhere in the body?	<input type="checkbox"/>	<input type="checkbox"/>
_____			Substance abuse problems?	<input type="checkbox"/>	<input type="checkbox"/>