HEALTH QUESTIONNAIRE

Name: _____ Nickname/Preferred Name: _____
Last First MI

Telephone: Home/Mobile_____ Work/Alternate _____

_____ _____ _____ _____
Social Security # Date of Birth Sex Referred By

_____ _____ _____
Home Address City State Zip

_____ _____
Primary Care Physician & Telephone # Dentist & Telephone #

Height _____
Weight _____

MEDICAL HISTORY

Please describe your current overall health: ○ Excellent ○ Good ○ Fair ○ Poor
Have there been any changes in your general health in the past year? ○ Yes ○ No
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? ○ Yes ○ No Date of last physical exam? _____
If yes, please describe_____

Have you ever been hospitalized or had a serious illness? ○ Yes ○ No
If yes, please describe_____

Have you ever had surgery? ○ Yes ○ No
If yes, please describe_____
_____
_____

MEDICATIONS

Preferred Pharmacy _____
Phone: _____

Are you currently prescribed or taking any of the following:

Antibiotics?	○ Yes ○ No	Prescription pain medication?	○ Yes ○ No
Anticoagulants or blood thinners?	○ Yes ○ No	Aspirin or drugs (eg. Motrin, Aleve, Ibuprofen)	○ Yes ○ No
Heart medications?	○ Yes ○ No	Insulin or oral anti-diabetic drugs?	○ Yes ○ No
Steroids – like cortisone or prednisone?	○ Yes ○ No	Blood pressure medications?	○ Yes ○ No
Antianxiety agents, antidepressants, or other psychiatric medications?	○ Yes ○ No	Bisphosphonates or other medications to strengthen your bones? (eg. Fosamax, Boniva, Prolia)	○ Yes ○ No
Cancer or chemotherapy drugs?	○ Yes ○ No	Any other medications or supplements?	○ Yes ○ No

Please list the specific medications indicated above and/or any other medications <u>not listed above</u> that you are currently taking. Please include all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication, dose and frequency	Medication, dose and frequency

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	◯Yes	◯No	Codeine or other pain control medications?	◯Yes	◯No
Food or food products?	◯Yes	◯No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	◯Yes	◯No
Sedatives or barbiturates?	◯Yes	◯No	Penicillin or other antibiotics?	◯Yes	◯No
Any other medications?	◯Yes	◯No	Any other drug allergies?	◯Yes	◯No

If yes, please describe _____
_____

REVIEW OF SYSTEMS

Please check Yes or No to the following conditions **You must check "Yes" or "No"**

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Asthma, Lung disease			Glaucoma			Diabetes		
Cough			Recent vision change			Auto-immune disease		
Tuberculosis			Blood disease			Seizures		
High blood pressure			Anemia, Transfusion			Stomach ulcers		
Stroke			Excessive bleeding			Arthritis		
Heart disease, Pacemaker			HIV/Aids			Artificial joint replacement		
Heart Attack			Hepatitis/Liver disease			Sleep apnea		
Chest pain/Angina			Kidney disease			Numbness in face		
Heart Murmur			Cancer			Sinusitis/ hay fever		
Rheumatic Fever			Radiation or chemotherapy			Other_____		

Please explain all "Yes" responses _____
_____
_____
_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? ◯Yes ◯No
If yes, please describe_____

FAMILY/ SOCIAL HISTORY

Does anyone in your family have a history of:

Problems with general anesthesia	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No
Bleeding Problems	◯ Yes	◯ No	Cancer	◯ Yes	◯ No
Heart Problems	◯ Yes	◯ No			

Check One: ◯ Married ◯ Single ◯ Divorced ◯ Widow(er)

Occupation: _____

Are you a student? If so what school and grade? _____

Have you ever smoked, vaped or chewed tobacco? ◯Yes ◯No If yes, for how long? _____

Do you use:

Alcohol? ◯Yes ◯No If yes, how often per week? _____
Marijuana? ◯Yes ◯No If yes, how often per week? _____
Recreational Drugs? ◯Yes ◯No If yes, how often per week? _____

Have you ever sought professional care or been hospitalized for:

Substance abuse ◯Yes ◯No
Emotional disorders ◯Yes ◯No
Alcoholism ◯Yes ◯No

Do you have difficulty with any physical movement that might affect the way we provide your care, such as standing, walking, etc.? ___◯___ Yes ___◯___ No Explain if yes: _____

Are there any disabilities or learning barriers we need to be aware of to administer your care? ___◯___ Yes ___◯___ No
Explain if yes _____ Hearing or speech impairment? ___◯___ Yes ___◯___ No
Preferred learning style: __ _ written __ _ verbal __ _ models __ _ demonstration

Nutrition: Describe your diet: ___◯___ Regular ___◯___ Soft ___◯___ Liquid ___◯___ Tube ___◯___ Diabetic
Appetite: ___◯___ Good ___◯___ Fair ___◯___ Poor
Nutritional Supplements you take: _____
Recent significant weight loss? ___◯___ Yes ___◯___ No

WOMEN
Are you pregnant? ___◯___ Yes ___◯___ No
Have you recently missed your menstrual period? ___◯___ Yes ___◯___ No
Are you taking birth control medication? ___◯___ Yes ___◯___ No If yes, List _____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? ◯Yes ◯No

To the best of my knowledge, the answers I have given to the above questions are correct. I understand that incomplete or inaccurate information could be detrimental to my treatment.

_____ _____
Date Patient Signature

If patient is less than 18 years of age or unable to sign:

_____ _____ _____
Name of responsible party Signature/ Date Relationship to patient

Personal medical/ social history and Review of Systems reviewed: _____
Physician signature/ Date

PATIENT NAME _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL

INSURANCE NAME: _____

INSURANCE ID#: _____

GROUP#/PLAN#: _____

INSURANCE ADDRESS: _____

_____

INSURANCE PHONE#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH _____

PATIENT RELATIONSHIP TO SUBSCRIBER:
◯Self ◯Spouse ◯Dependent ◯Other _____

SECONDARY DENTAL

INSURANCE NAME: _____

INSURANCE ID#: _____

GROUP#/PLAN#: _____

INSURANCE ADDRESS: _____

_____

INSURANCE PHONE#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH _____

PATIENT RELATIONSHIP TO SUBSCRIBER
◯ Self ◯ Spouse ◯ Dependent ◯ Other_____

I authorize the release of any information that may be necessary to process this claim to my insurance company.

Signed Date

MEDICAL INSURANCE INFORMATION

PRIMARY MEDICAL

INSURANCE NAME: _____

INSURANCE ID#: _____

GROUP#/PLAN#: _____

INSURANCE ADDRESS: _____

_____

INSURANCE PHONE#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH _____

PATIENT RELATIONSHIP TO SUBSCRIBER:
◯Self ◯ Spouse ◯Dependent ◯Other _____

SECONDARY MEDICAL

INSURANCE NAME: _____

INSURANCE ID#: _____

GROUP#/PLAN#: _____

INSURANCE ADDRESS: _____

_____

INSURANCE PHONE#: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH _____

PATIENT RELATIONSHIP TO SUBSCRIBER:
◯Self ◯ Spouse ◯Dependent ◯Other _____

I authorize the payment of any medical or dental benefits otherwise payable to me, be made to the doctor's office. I understand that any amount not covered by insurance is my responsibility.

Signed Date

ORAL & FACIAL
surgery group, p.c.

John R. Werther, D.M.D., M.D., F.A.C.S.
Oral & Maxillofacial Surgery
Facial Cosmetic & Reconstructive Surgery

Financial Policy and Agreement

We are dedicated to providing the best possible care and service to you. We feel that complete understanding of your financial responsibilities for treatments is an essential element of your care in our practice. In order to better help you understand the financial aspects of your care, we have adopted the following financial policies and agreement. We know that you have many choices of health-care providers, and we are honored and happy to assist you. For your convenience, we accept Visa, Discover, MasterCard, and American Express as well as cash or check.

Your health insurance policy is a contract between you and your insurance company, not the doctor. As a courtesy, we will assist you in **estimating** what your benefits will likely be. The actual amounts of coverage may vary from this estimate. Many insurance plans have coverage limitations and exclusions. For example, certain procedures may not be covered or may be covered up to a certain yearly limit. We will do our best to assist you in determining this information but are not obligated to be aware of all policy variations of all of our patients. Just as we are obligated to provide you appropriate medical and dental care in good faith, you ultimately are responsible for understanding your insurance coverage and limitations. We are happy to assist you with filing benefits with your primary insurance carrier. If you wish to submit your claim to any secondary carriers, please let us know up front. **Please be aware that we are <u>out-of-network</u> with ALL MEDICAL INSURANCE PLANS and <u>most</u> dental insurance plans**. We can still provide your care, but your coverage will almost always be less than with an in-network provider.

<u>Financial Policy</u>

A. If we are a participating provider with your *dental* insurance company:

1. All co-pays, deductible amounts, and charges exceeding any yearly coverage limitations as well as procedures or services are "not covered" for any reason that you wish to have provided **are due at the time of office visit & up to 14 days before surgery for certain complex procedures.**

2. If your insurance company does not pay the practice within a reasonable length of time, you remain liable for payment.

B. If we **<u>do not participate</u>** with your insurance company:

1. For certain complex procedures, pre-payment is required; otherwise, full payment is due at the time service is rendered. For surgery to be done in the operating room, full payment is due at the final pre-surgical visit.

2. As a courtesy, we will attempt to estimate your insurance payments (if any), prepare and send the claim to your insurance company. This means that the insurer may pay you directly. If we receive insurance payment that results in a credit to your account, we will forward that amount to you. As a non-participating provider, the amount paid by your insurance company will most likely be less than our fee. You are responsible for the difference.

C. **Outstanding balances** will be charged interest at 1.5% per month (18% A. P. R.) in addition to a late charge of $15.00 per billing cycle. Failure to make proper payments on the amount owed may result in the account, becoming delinquent and being turned over for collections. You will be responsible for all collection costs and reasonable legal costs, in addition to the amount originally owed.

D. **Divorce**: Please be aware that the parent who initially brings the child to the office for treatment and signs as the patient's guarantor is ultimately responsible for payment.

<u>Agreement</u>: I have read and understand the financial policy of the practice and I agreed to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice and upon written notice thereof I agreed to be bound by those amendments.

_____ _____

Signature of Patient/ Responsible Party if a minor Date

_____(Printed Patient Name) _____Witness

Authorization and Consent
To Send ***Unencrypted*** Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize *Oral & Facial Surgery Group, P.C.* to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, and/or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or *Oral & Facial Surgery Group, P.C.* health care operations. The patient information that may be emailed may include my x-rays, photographs, health history, diagnosis, treatment, and payment records.

I understand that:

- The primary purpose of this release is to facilitate timely and comprehensive communication between *Oral & Facial Surgery Group, P.C.* and my doctors to improve patient care.
- I do not have to sign this form.
- All electronic communication—whether encrypted or not—is subject to being improperly acquired by hackers, governments, others or received by unintended recipients. Edward Snowden has convincingly demonstrated this on behalf of the National Security Agency. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, *Oral & Facial Surgery Group, P.C.* may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- *Oral & Facial Surgery Group, P.C.* does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that *Oral & Facial Surgery Group, P.C.* already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

ORAL & FACIAL
surgery group, p.c.

John R. Werther, D.M.D., M.D., F.A.C.S.
Oral & Maxillofacial Surgery
Facial Cosmetic & Reconstructive Surgery

Oral & Facial Surgery Group, P.C.

Your privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Oral & Facial Surgery Group P.C. I Hereby authorize, as indicated by my signature below, Oral & Facial Surgery Group P.C. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purposes.

_____ _____
Print Name **Address**

_____ _____
Signature **Date**

Please check your acceptable/preferred means of communication so that we may contact you: (CHECK ALL THAT APPLY)

- o You may contact me at my home telephone Number_____
- o You may contact me on my mobile telephone number _____
- o You may contact me on my work telephone Number_____
- o You may send me an email at: _____
- o Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in Addition to custodial parents and legal guardians:

1._____ Date Added/ Removed: _____

2._____ Date Added/ Removed: _____

3. _____ Date Added/ Removed: _____

4. _____ Date Added/ Removed: _____

***

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (Please Specify) _____

Staff Person Initials_____

For office staff use - HEALTH HISTORY REVIEW

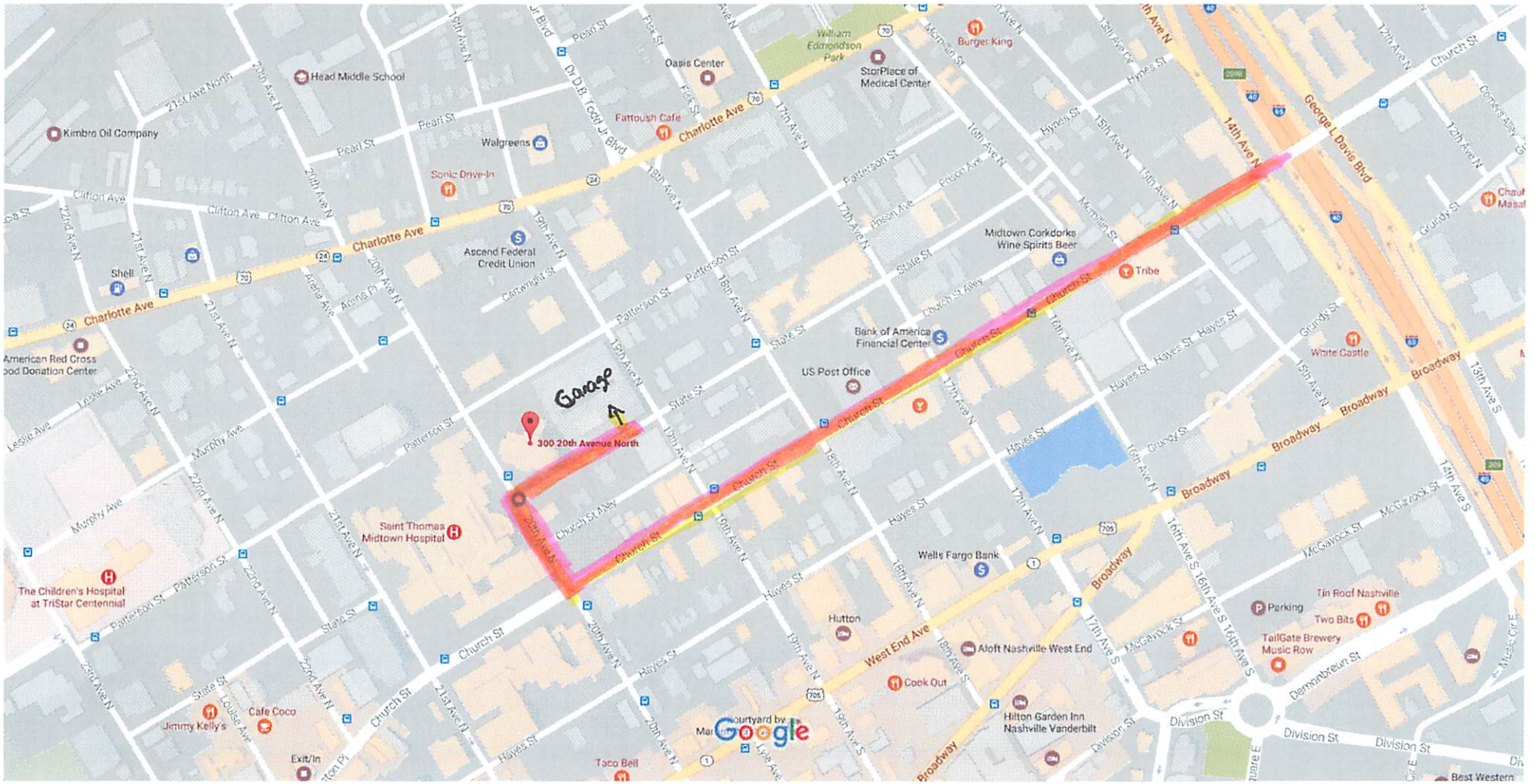
Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

Google Maps

300 20th Ave N

From I40 (East or West) take the **Church Street Exit**. Head west on Church Street (moving away from downtown). Go about 6 blocks to **20th Avenue**. Turn RIGHT onto 20th Avenue. St. Thomas Midtown Hospital will be on your left. Turn on the first road to the RIGHT which will be **State Street**. The Patient Parking Garage will be on the immediate LEFT. The 20th Avenue Medical Office Building sits diagonally facing St. Thomas Midtown ER and main entrance. Once parked in the garage take garage elevators to 2nd floor where there will be an entrance to the crosswalk to the building. When entering the building, you will now be on the first floor. Take elevators up to the 6th floor and we are in suite 606.



Map data ©2017 Google, Nashville Davidson County 200 ft