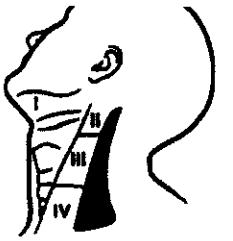
NextGen
Oral MaxilloFacial & Reconstructive
Surgery Center



Siavash Eftekhari, DMD, MD

Primary Care Doctor & Dentist

Patient Name: _____

Referred by: Name: _____ Phone #: _____ **Dentist:** Name: _____ Phone #: _____ **Primary Care Doctor:** Name: _____ Phone #: _____	**Additional Doctor(s):** Name: _____ Specialty: _____ Phone #: _____ Name: _____ Specialty: _____ Phone #: _____ Name: _____ Specialty: _____ Phone #: _____

Pharmacy Name: _____ Phone Number: _____

NextGen
Oral MaxilloFacial & Reconstructive Surgery Center

Siavash Eftekhari, DMD, MD

Patient Name: _____

Date of Birth: _____

Age: _____

SSN: _____

Home Address:

_____

_____

_____

Email Address: _____

Cell Phone #: _____

Text ok? [ ] YES [ ] NO

Emergency Contact

Name: _____

Phone #: _____

Relationship to patient: _____

Please attach a copy of patient's drivers license, all insurance cards, x-rays, referrals, and pathology reports

Medical Insurance

Primary Medical Insurance:

_____

Subscriber ID #: _____

Group #: _____

Insurance Phone #: _____

Subscriber Name #: _____

Subscriber DOB: _____

Secondary Medical Insurance:

_____

Subscriber ID #: _____

Group #: _____

Insurance Phone #: _____

Subscriber Name #: _____

Subscriber DOB: _____

Dental Insurance

Dental Insurance:

_____

Subscriber ID #: _____

Group #: _____

Insurance Phone #: _____

Subscriber Name #: _____

Subscriber DOB: _____

NextGen
al MaxilloFacial & Reconstructive Surgery Center

Siavash Eftekhari, DMD, MD

Patient Name: _____ DOB: _____ Today's Date: _____

History & Physical Intake Form

What is your current ***Height***_____ ***Weight***_____ Food/ Drug Allergies? _____

Past Medical History: (Circle any area that applies to you)

Allergy Prone
Hay Fever
Latex
Sinusitis
Seasonal

Bone or Joint
Arthritis, Rheumatism
Artificial Joint when:
_____
Back Problems
Surgical Implant

Cancer
Where:
_____
Chemotherapy
Radiation Therapy

Circulation
AIDS/HIV
Anemia
Bleeding Problems
Blood Disease
Blood Transfusion
Feet/Ankle Swelling
Hemophilia
High Blood Pressure
Emphysema

Cortisone Treatment

Diabetes:
Recent Hemoglobin A1C: _____
Recent Blood Sugar: _____
Any Diabetic Emergencies Ever: [ ] YES [ ] NO

Glaucoma

Heart
Angina (chest pain)
Heart Disease or Failure
Heart Attack
Heart Murmur
Heart Surgery (bypass)
Pacemaker
Rheumatic Fever
Stroke

Kidney Disease/Transplant
Liver Disease
Hepatitis Type: A B C

Lung Disease
Asthma:
Any ER visits, hospitalizations for asthma?
[ ] YES [ ] NO When: _____
Bronchitis
Pneumonia
Shortness of Breath
TB

Nervous Problems
Epilepsy
Seizures
Psychiatric Care

Skin Problems
Skin Cancer
Herpes
Cold Sores

Sleep Disorder
Snoring
Sleep Apnea/ CPAP Machine

Thyroid Disease

Tonsillitis
Mouth Ulcers

Tobacco
Smoke (pack per day _____)
Dip
# of years _____

Past / Present Alcohol use:
Yes / No
How often per week: _____

Past / Present Drug use:
Yes / No
When: _____
How often per week: _____

If you have High Blood Pressure or history of Heart Disease:
Any recent chest pain? [ ] YES [ ] NO Any shortness of breath? [ ] YES [ ] NO
Able to go up 3 flights of stairs? [ ] YES [ ] NO

List other past/current Medical Conditions:

_____
_____

List past surgeries (even childhood) with dates:

_____
_____

Medical Alert (All Patients):

Are you now or have you ever been treated with **oral intravenous bisphosphonates** (bone strengthening medications) for **Osteoporosis/Osteopenia/Arthritis/Cancer/Bone Metastases**? Failure of disclosure can lead to complications in bone healing (Osteonecrosis of the jawbone) which are very difficult to treat and is a serious side effect of these medications.

Are you using or have you used any of the oral IV bisphosphonate medications? [ ] YES [ ] NO

Example of oral forms: Fosamax, Actonel, Skelid, Didronel, Boniva **Examples of intravenous forms:** Zometa, Aredia

If YES, please specify medication and reason for taking medication and for how many years. _____

Any history of patient/family issues with ANESTHESIA (difficulty getting numb, waking up in the middle of surgery, fevers during anesthesia, nausea/vomiting or slow to wake up) or bleeding: [ ] YES [ ] NO if YES, please explain._____

Any fevers, coughs, sore throats, runny nose, active infection in the last week: [ ] YES [ ] NO

If YES, please explain. _____

Any history of recent hospitalization? [ ] YES [ ] NO if YES, please explain_____

Review of My Symptoms

YES	NO	Symptoms	YES	NO	Symptoms
		Snoring			Swelling
		Pain with chewing			Limited mouth opening
		Recent dental work			Pus (infection in your mouth, face, or neck)
		Sinus pain			Difficulty swallowing
		Bad breath			Pain on swallowing
		Difficult breathing, shortness of breath			Numbness or tingling on face or neck
		TMJ pain			Fever or chills
		Dry mouth			Facial or Oral / Jaw pain
		Nose bleeding			Nausea / Vomiting
		Neck pain			Voice change

Current Medication List

(Please list ALL medications that you are currently taking or have within the last year)

Please provide us with a current list of medications if you have one

_____ _____ _____

_____ _____ _____

_____ _____ _____

Women:

Is there any reason to suspect you may be pregnant? [ ] YES [ ] NO

Pregnancy: I understand that if there is a possibility of current pregnancy, surgery will be postponed (only IV Sedation/General Anesthesia) until I complete either a home or blood pregnancy test prior to scheduling IV sedation/general anesthetic procedure and report results to my treating surgeon. Medication used during surgery and post-operative period can adversely affect the developing baby.

Are you on birth control? [ ] YES [ ] NO

Birth control pills: Antibiotics are commonly prescribed during your surgical management. Antibiotics can decrease the efficacy of the birth control pill leading to pregnancy. It is recommended that a second alternative from birth control be used for the full cycle (month) if pregnancy is not desired.

Are you breast feeding? [ ] YES [ ] NO **if YES please talk to your PCP prior to sedation.**

Authorization: the responses to this questionnaire are accurate to the best of my knowledge. If there is any change in my medical status. I will inform the doctor. I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges, whether paid or not by insurance, and for all services rendered on my behalf or for my dependents. I understand and authorize all dishonored check, pus processing fee with applicable taxes to be electronically debited from my account.

***Recreational drug use, overdose with medication, or excessive alcohol consumption can adversely affect the liver function which is critical for producing blood clotting factors. Disclosure will allow your surgeon to safely treat you and prevent excessive post-surgical bleeding and can be life threatening.**

***Current recreational drug use: Interaction with local anesthesia and IV sedation agents can be life threatening. Full disclosure is critical for safe management information is strictly confidential.**

Signature: _____ **Date:** _____

Care taker/ Guardian: _____ Date: _____

Siavash Eftekhari, DMD, MD

PATIENT RESPONSIBILITY & MEDICAL REALEASE FORM

_____ 1. INDIVIDUAL'S FINANCIAL & TREATMETN PLAN RESPONSIBILITY
Initial

- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
- All planned treatment plan and procedures were discussed with me in detail and I understand and agree with them and my financial responsibilities.

_____ 2. INSURANCE AUTHORIZATION FOR ASSIGMENT OF BENEFITS
Initial

- I hereby authorize and direct payment of my medical benefits to *Facial, Head & Neck Surgery PLLC (Dr. Eftekhari),* on my behalf for any services furnished to me by the providers.

_____ 3. AUTHORIZATION TO RELEASE RECORDS
Initial

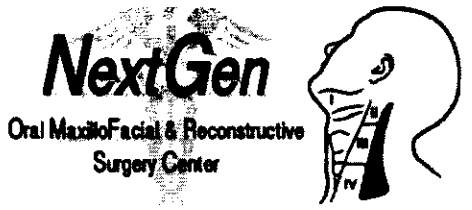
- I hereby authorize *Facial, Head & Neck Surgery PLLC (Dr. Eftekhari)* to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.
- I authorize release of all my related medical information and records to Dr. Eftekhari's office.

_____ 4. MEICARE REQUEST FOR PAYMENT
Initial

- I request payment of authorization Medicare benefits to me or on my behalf for any services furnished me by or in *Facial, Head & Neck Surgery PLLC (Dr. Eftekhari.)* I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Date



Siavash Eftekhari, DMD, MD

Acknowledgement of Receipt Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description or how your Protected Health Informa-tion may be used or disclosed. It describes your rights as they concern the limited use of health Information, including your demographic Information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice or Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure or your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information,
If we agree to your request, the restriction will be binding with our office, Use or disclosure of protected Infor-mation in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health information, However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent Is received will not be affected.

I give permission for the use and disclosure of my health information as set forth above.

Patient or Legally Authorized Individual Signature

Date: _____ Time: _____

Print Patient's Full Name: _____

Witness Signature

Date: _____ Time: _____

Siavash Eftekhari, DMD, MD

HIPPA RELEASE OF INFORMATION AUTHORIZATION

Consent for access to Protected Health Care Information:

I give consent to the staff at NextGen OMS to communicate with the person(s) listed below regarding my medical records. I consent to the use of my Protected Health Care Information when communicating with the person(s) below. NextGen OMS may communicate in person, by telephone, mail, e-mail, fax, or other means. I may withdraw this consent at any time by notifying Next Gen in writing. Any communication prior to such notice will be considered to have been authorized by me.

Patient Name_____ Date_____

PLEASE LIST NAMES OF PERSONS OR FAMILY
YOU AUTHORIZE TO RECEIVE INFORMATION ABOUT YOU.

Name_____ Relationship to Patient_____
Name_____ Relationship to Patient_____
Name _____Relationship to Patient_____
Name_____ Relationship to Patient_____

This authorization will expire on: _____/_____/_____

Patient Signature_____

NextGen Oral Maxillofacial and Reconstructive Surgery

Financial Policy

We strive to provide the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have questions, please discuss them with our office manager.

Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT TIME OF SERVICE. For your convenience we accept cash, check, Master Card, Visa, Discover, American Express and Care Credit.

Your insurance policy is a contract between you and your insurance company, our practice is not involved. As a courtesy, we will bill your insurance plan directly. Any co-payment, co-insurance or deductible is payable at the time of service. You are responsible for ANY amount that insurance does not pay. We will do our best to estimate insurance payment before any procedures are performed, but often dealing with insurance companies is unpredictable. You are responsible for the remaining balance (if any) after the insurance payment.

You understand that if your insurance company sends you a check, you are obligated to bring that payment to us. Please understand that we will pursue legal action or use a collection agency if this is not done in a timely manner.

Please be aware that some, if not all, of the services you receive may not be covered by your insurance carrier. You must pay for these services in full at the time of visit or when you receive notification from our billing office.

If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining one. Failure to obtain the referral and/or pre-authorization may result in lower or non-payment from the insurance company.

Accounts past due more than 60 days may incur interest charges and no services will be rendered by this office (appointments, forwarding of images or prescription refills) until the balance is paid in full.

Appointment Policy

We respect that your time is valuable; therefore, we make every effort to see our patients at their scheduled time. As a courtesy to our staff and other patients, if you are 15 minutes late for your scheduled appointment, we may need to reschedule you for another date and time.

We request that our patients ***call our office*** at least 48 hours prior to their scheduled time to cancel an appointment. Appointments that are cancelled with less than 48 hours notice are considered a Broken Appointment and may be subject to a cancellation fee of $50.00

1st Broken Appointment - The patient may be charged a cancellation fee of $50.00

2nd Broken Appointment - The patient is charged a cancellation fee and may be required to pre-pay for their next appointment.

I have read and understand the financial and appointment policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____

Print name of responsible party Date

_____

Signature