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APEX
Oral Maxillofacial Surgery & Implantology

39 Simon Street, Unit 11
Nashua, NH 03060
15 Constitution Drive, Suite 2B
Bedford, NH 03110
T: 603.883.4008 | F: 603.881.3822

Today's Date: ______________________

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name ____________________ M.I. ________ Last Name ______________________

Birth Date _________________ Age _________ Sex Assigned at Birth ☐ M ☐ F Prefers to be called ______________

Street/Apt # ____ City ______________ State _______ Zip ________

Cell Phone _____________________________ Home Phone ______________ Email _________________________

By providing email/cell phone, you consent to receive unencrypted appointment, treatment and/or financial information

SS# ____________________________ Referring Dentist/Provider ____

Student ☐ Full Time ☐ Part Time ☐ Not School ____

Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Other

Employed ☐ Full Time ☐ Part Time ☐ Not Employer ____________________________________

If patient is under 18:

Mother's Full Name ____ Cell Phone _____________________________

Father's Full Name ____ Cell Phone _____________________________

Are you or any family member a prior patient? ☐ Yes ☐ No Please list other family ______________________

In case of emergency, please contact:

Name _______________________________________ Relation to Patient ____________________________

Cell Phone ____________________________________ Home Phone _________________________________

Do you require any special accommodations for your appointment, such as ramp, ASL interpreter, etc. ☐ Yes ☐ No

If yes, please describe ____

Does patient have a power of attorney (POA) or legal guardian? ☐ Yes ☐ No If yes, please complete section below

WHO IS RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self – Must be 18 or older with no POA or guardian – Skip This Section

Responsible party must be present at appointments to sign financial agreements, make payments or make prior arrangements.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name ________________________________ Last Name ______________________

Cell Phone _________________ Email ___________________________ Relation to Patient _______________________

Street/Apt # ____ City ______________ State _______ Zip ________

INFORMATION BELOW PERTAINS TO THE PERSON WHO HOLDS THE INSURANCE – PLEASE PROVIDE COPY OF CARDS

By providing email/cell phone, you consent to receive unencrypted appointment, treatment and/or financial information.

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name __________________________________

Group # __________________ ID# _______________

Policy Holder/Subscriber _________________________

Birth Date _________________ SS# _______________

Relation to Patient _____________________________

Cell Phone ___________Employer _________________

SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name __________________________________

Group # __________________ ID# _______________

Policy Holder/Subscriber _________________________

Birth Date _________________ SS# _______________

Relation to Patient _____________________________

Cell Phone ___________Employer _________________

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name ______________________ Group # ______________ ID# ________________

Policy Holder/Subscriber ______________________ Birth Date ______________ SS# ________________

Relation to Patient ______________________ Cell Phone ______________ Employer ________________

Please provide a copy of your insurance card(s) prior to your first appointment.
Copies of insurance cards may be texted to **603.883.4008** or emailed to **info@apexomfs.com**.
Social security numbers are used to verify insurance coverage. If not provided, payment will be expected in full.

IF 65 OR OLDER – MEDICARE OPT OUT

By signing below, I fully acknowledge and understand that Apex OMFS & Implantology LLP (the "practice"), and its doctors, have **opted out** of all Medicare programs, and that I cannot submit (or request that the practice submit) a claim to Medicare or its agents for any services provided, even if such services would otherwise be covered. I understand that I have the right to have services provided by other oral maxillofacial surgeons or other practitioners who participate in Medicare. I acknowledge that Medigap plans and other supplemental insurance will not pay for services either. I understand that I am being asked to enter a private contract for services.

Patient Signature ______________________________________

HIPAA CONSENT FORM

I acknowledge that I have been offered to read a copy of the practice's Notice of Privacy Practices, either online or printed.
I have been given the opportunity to ask questions I may have regarding this Notice.
I hereby give permission for Apex to contact the responsible person above and the following person(s) regarding my treatment and/or finances:

Printed First and Last Name ___________________________ Relation ____________________

Printed First and Last Name ___________________________ Relation ____________________

PATIENT HEALTH HISTORY

General Dentist ______________________

Location ______________________

Estimated Last Visit ______________________

Primary Care ______________________

Phone ______________________

Estimated Last Visit ______________________

Specialist 1 ______________________

Specialty ______________________

Phone ______________________

Estimated Last Visit ______________________

Specialist 2 ______________________

Specialty ______________________

Phone ______________________

Estimated Last Visit ______________________

Although oral surgeons primarily treat areas in and around your mouth, your mouth is part of your entire body. Health problems you may have, or medication that you may be taking, could be relevant to the care you will be receiving. Thank you for answering the following questions. Your answers are for healthcare purposes only and are considered confidential.

What is your weight? __________ What is your height? __________ If yes to any questions below, please explain/list:

Any changes to your general health in the past year?	☐ Yes	☐ No	________________
Are you under the care of a physician or specialist?	☐ Yes	☐ No	________________
Have you had any hospitalizations in last 5 years?	☐ Yes	☐ No	________________
Any operations/surgeries since birth?	☐ Yes	☐ No	________________
Do you have a prosthetic non-dental joint/implant?	☐ Yes	☐ No	________________
Do you have any heart valve replacement or vascular graft?	☐ Yes	☐ No	________________
Do you ever pre-medicate w/ antibiotics for dental appts?	☐ Yes	☐ No	________________

PATIENT HEALTH HISTORY - CONTINUED

Have you ever had sedation / anesthesia or been put to sleep for a procedure?

☐ Yes ☐ No ____________________

Is there any condition concerning your health of which the doctor should be informed?

☐ Yes ☐ No ____________________

Do you have or have you had any of the following conditions:

Cardiovascular	YES	NO
High blood pressure		
Low blood pressure		
Fainting spells		
Chest pain/angina		
Heart attack(s)		
If so, when ____________		
Heart murmur		
Rheumatic fever		
Irregular heart beat / atrial fibrillation		
Cardiac pacemaker		
Heart surgery		
If so, when/what____________		
Damaged / artificial heart valve(s)		

Musculoskeletal		
Arthritis / joint disease		
Prosthetic implant / joint replacement		
Where/when ____________		
Osteoporosis or osteopenia		
If yes, what medications ________		
Osteonecrosis / osteomyelitis		

Immune System		
Problems with immune system		
Delay in healing		
Contagious diseases		
Infectious mononucleosis		
Sexually transmitted diseases		

Neurologic / Psychiatric		
Stroke		
If yes, when ____________		
Convulsions or epilepsy		
Mental health problems		
Describe ____________		
Eye disease / glaucoma		

Respiratory	YES	NO
Hay fever / sinus problems		
Pneumonia / bronchitis /chronic cough		
Asthma		
Emphysema		
Snoring		
Sleep apnea /CPAP use		
Difficulty breathing		
Other respiratory problems		
Tuberculosis		
Do you smoke or vape		
If so, how much per day ______		
For how many years ________		
Do you use marijuana		
If so, how much per day ______		
For how many years ________		
Do you use chewing tobacco		
If so, for how long ________		

Endocrine		
Thyroid disease / cancer		
Diabetes		
Type I or II (circle one)		
Last HbA1c ____________		
Low blood sugar		
Adrenal gland disorders		

Gastrointestinal / Genitourinary		
Stomach ulcers / acid reflux		
Crohn's disease, ulcerative colitis		
Irritable bowel syndrome		
Hepatitis, jaundice or liver disease		
Gallbladder disease		
Kidney disease		
Are you on dialysis		
If so, what days ____________		

PATIENT HEALTH HISTORY - CONTINUED

Hematologic	YES	NO
Anemia		
Abnormal bleeding / Von Willebrand Disease		
Hemophilia		
Abnormal clotting (Factor V Leiden)		
Other blood disorder		
If yes, what ___________________________		
Blood transfusion		

Other	YES	NO
Anesthesia complications		
History of alcohol use disorder		
History of substance use disorder		
History of recreational drug use		
History of cancer, tumors, other growths		
History of chemotherapy treatment		
History of radiation treatment		

MEDICATIONS AND ALLERGIES

Are you now taking:	YES	NO
Blood thinners – Coumadin, Aspirin, Eliquis, Xarelto, Plavix, Effient, Brilinta, Fish Oil		
Muscle relaxants		
Antidepressants		
Diet medication – Ozempic, Wegovy, etc.		
Insulin / diabetes medication		
Immunosuppressant medications		
Bone density meds (RANKL inhibitors or bisphosphonates), Prolia / Xgeva, Fosamax, Boniva, Actonel, Zometa, Aredia or Reclast When / how long _____________________		

Allergies	YES	NO
Penicillin / Amoxicillin		
Other antibiotics		
Local anesthetic / numbing medicine		
Benzodiazepines / Valium / other sedative agents		
Aspirin / Ibuprofen / NSAIDs		
Codeine or other narcotics – such as Fentanyl, Hydrocodone		
Latex		
Eggs / Soy		
Sulfites		

Have you ever taken:	YES	NO
Stimulants, tranquilizers or narcotics/pain killers on a regular basis		
If yes, please list: _________________		

Family History Of	YES	NO
Cancer		
Heart disease		
Anesthesia complications		
Malignant hyperthermia		

Please list any other drug allergies:

____

____

____

____

____

Please list any allergies other than drug allergies:

____

____

____

____

____

YOUR PHARMACY

Pharmacy: ___________________________________ Address: ___________________________ City/Town: ____________________

YOUR MEDICATION LIST Please list ALL medication(s) you take (including natural, herbal and homeopathic products):

Medication	Dosage	Frequency	Medication	Dosage	Frequency

ADDITIONAL INFORMATION

Are you nervous about possibly needing oral surgery? ☐ Yes ☐ No

Do you have, or have you ever been, diagnosed with, or treated for, TMJ disorder? ☐ Yes ☐ No

Do you have any neck or back pain / disorders that would make sitting in dental chairs a difficulty? ☐ Yes ☐ No

Please describe any other medical problems or conditions that might affect your treatment in this office? ☐ Yes ☐ No

If yes please explain ____________________

Is there anything you would like to discuss in private with your surgeon? ☐ Yes ☐ No

For women only:

Are you pregnant or is there a chance you may be pregnant? ☐ Yes ☐ No

If yes, what is the expected delivery date? ____________________

Are you currently breast feeding? ☐ Yes ☐ No

Please initial:

__________ I understand the potential for serious adverse consequences from surgery and/or anesthesia during pregnancy, to include harm to the fetus.

POWER OF ATTORNEY / LEGAL GUARDIAN

Please complete this section, if applicable.

Please provide a notarized copy of any power-of-attorney (POA) or legal guardianship prior to appointment, send to info@apexomfs.com. Any patient who has an appointed POA or legal guardian, such POA or legal guardian MUST accompany the patient during any and all appointments in this office.

Does the POA/legal guardian make treatment decisions, financial, or both? ☐ Treatment ☐ Financial ☐ Both

Is this a DURABLE POA (meaning the POA only applies if patient is incapacitated)? ☐ Yes ☐ No

Who is responsible: Name ____________________ Relation ____________________

Cell Phone ____________________ Email ____________________

SIGNATURE

The undersigned represents and warrants that the above information is complete and correct.

X______________________________ x____________________

Patient Signature (if 18+ years old and no POA or legal guardian) Date

Parent Signature (if Patient is <18 years old)

Power of Attorney / Legal Guardian (if applicable)

INTERNAL OFFICE:

Clinic (Initials): X______________ X____________ Date

Doctor (Initials): X______________ X ____________ Date

FINANCIAL POLICY / INSURANCE INFORMATION

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are available to try to help you receive your maximum allowed benefits.

We strive to deliver the finest care at the most reasonable cost to our patients. We ask that payment be made at the time service is rendered. For your convenience, we accept checks, cash, debit cards, Visa, MasterCard, Discover and Care Credit. Care Credit is a healthcare credit program offered to patients by an independent company. This allows payment over time and takes only a few minutes to determine eligibility. Visit www.carecredit.com for more information. If you have questions regarding your account, please contact us at (603) 883-4008 or info@apexomfs.com. Many times, an email, text or phone call will clarify any questions or misunderstandings.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Not all services are a covered benefit in all insurance contracts. Insurance companies differ in their policies regarding coverage of procedures or services that a doctor may provide. They may arbitrarily select certain services they will not cover. Depending on your specific policy, it may require you, as the subscriber, to pay nothing, a deductible, or a portion of the fee; or it may require you to pay for the entire procedure or service.
2. We choose not to participate in managed care/PPO/HMO contracts with medical insurances because we feel it will not allow us to provide the level of care and service that our colleagues and patients have come to expect of us and that we demand of ourselves. However, some of these plans with "out of network" benefits will reimburse you for your portion of your total cost, in addition to any dental insurance coverage you may have.
3. Your insurance is a contract among you, your employer, and your insurance company. We are not a party to that contract. We must emphasize that our relationship is with you, the patient, and not the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, you are fully responsible for all fees and charges by this office regardless of your insurance coverage.

FEES AND PAYMENTS

We make every effort to minimize the cost of your oral surgical care. We are happy to offer pre-treatment estimates for major surgeries. Please be aware that this is an estimate only and charges may actually be higher or lower depending on the nature of your procedure. Insurance coverage estimates may also vary, being higher or lower, depending on deductibles and pending claims that are processed after we review coverage. You should be aware that any other treatment you may have already received will reduce your remaining benefits allowed by your dental insurance contract.

Most insurance companies will process claims within 30-90 days. Please call our office if your statement does not reflect your insurance payment within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated. If questions, we encourage you to contact us promptly for assistance in the management of your account.

Payment by check is always welcomed, however, if your check is returned for insufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. Returned checks are subject to a $40 fee and balances over 90 days may be subject to interest charges of 1.5% per month or 18% per year and any additional collection fees. Charges may also be made for broken appointments and appointments canceled without 24-hour advance notice.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs for any unpaid balance. This signature on file is authorization for the release of information necessary to process any claim. I hereby authorize payment to Apex OMFS & Implantology, LLP of the benefits otherwise payable to me.

We appreciate the opportunity to care for you/the patient. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

AUTHORIZATION

I hereby authorize my surgeon and his/her designated staff to perform an oral maxillofacial surgery examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays and other scans 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.

X____ x____________________

Patient Signature - 18+ years old <u>and</u> Responsible for Payment Date

X____ x____________________

Parent, POA or Legal Guardian Signature - Responsible for Payment (regardless of Patient Age) Date

____

PLEASE PRINT FULL NAME of Parent, POA or Legal Guardian