Dr. Dale R. Duncan
North Atlanta Oral and Maxillofacial Surgery

2555 Westside Parkway
Suite 350
Alpharetta, GA 30004
Telephone: (770) 664-6533
Fax: (470) 745-0659

3275 Market Place Boulevard
Suite 175
Cumming, GA 30041
Telephone: (770) 406-2060
Fax: (470) 745-0659

PATIENT INFORMATION

PATIENT NAME (please print): _____ _____
First MI Last

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ HOME EMAIL: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

SEX: _____ AGE: _____ BIRTHDATE: _____/_____/_____ MARITAL STATUS: _____

PATIENT EMPLOYER/SCHOOL: _____

OCCUPATION: _____ WORK PHONE: (_____)_____

SPOUSE/PARENT(S)NAME(S) (with whom patient lives): _____

EMPLOYER: _____ WORK PHONE: (_____)_____

HOME PHONE: (_____)_____CELL PHONE: (_____)_____

GUARANTOR INFORMATION –*INDIVIDUAL RESPONSIBLE FOR PAYMENT*

PERSON RESPONSIBLE FOR ACCOUNT: _____
First MI Last

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ CELL PHONE: (_____)_____

EMPLOYER: _____ WORK PHONE: (_____)_____

DRIVER'S LICENSE #: _____ STATE: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ D/O/B: _____/_____/_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE: (_____)_____ REFERRED BY: _____

DUE TO OUR PRIVACY POLICIES UNDER HIPAA, PLEASE INFORM THE OFFICE OF THE FOLLOWING:
IS IT OK TO LEAVE A MESSAGE ON YOUR VOICE MAIL OR WITH A FAMILY MEMBER? Y / N
IS IT OK TO CALL YOU AT WORK? Y / N

_____ _____/_____/_____
PATIENT OR RESPONSIBLE PARTY DATE

REVISED 09/18

Dr. Dale R. Duncan

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HEALTH HISTORY

PATIENT'S NAME_____ **DATE** _____/_____/_____

1. **Family Physician** Name _____Phone_____
   Address _____
2. **Pharmacy** Name _____Phone_____
   Address _____
3. **Specialist** Name _____Phone_____
   Address _____
4. **Family Dentist** Name _____Phone_____
   Address _____

5. Have you taken any medicine or drugs during the past two years? CIRCLE: yes / no

6. Are you now taking any medications, drugs, or pills? **This includes any bone building drugs (Bisphosphonates) such as Actonel, Boniva, Fosamax, Zometa, etc.** If so, please list medicine and dosage –**please include Herbal Meds/Supplements**:_____
_____

7. Are you allergic or have you reacted adversely to any of the following medications? CIRCLE:

Aspirin	Nitrous Oxide	Local Anesthetic
Valium	Scopolamine	(Novocaine or Xylocaine)
Darvon	Erythromycin	Sleeping Pills
Codeine	Tetracycline	(Nembutal or Seconal)
Demerol	Penicillin	Ibuprofen
Percodan	Other Antibiotics	Latex

Are you aware of being allergic to any other medication or substance? CIRCLE: yes / no
If so, please list: _____

8. **Height:** _____ **Weight:** _____ Regular Exercise/Sport: _____
   Alcohol: _____ Tobacco: _____ Snoring/Sleep Apnea: _____
   Date of last physical: _____/_____/_____

9. **Circle** any of the following that you, the patient, have had or have at the present.

NOTE: It is imperative that all conditions, diagnoses, diseases are disclosed!

		Other Conditions Diagnosed/Date
Heart Failure	Emphysema	1._____
Heart Disease or Attack	Cough	_____
Angina Pectoris	Tuberculosis	Additional Info: _____
High Blood Pressure	Asthma or Shortness of Breath	_____
Heart Murmur	Hay Fever	_____
Rheumatic Fever	Sinus Trouble	2._____
Congenital Heart Lesions	Allergies or Hives	_____
Scarlet Fever	Diabetes	Additional Info: _____
Artificial Heart Valve	Thyroid Disease	_____
Heart Pacemaker	X-ray or Cobalt Treatment	_____
Heart Surgery	Chemotherapy(Cancer, Leukemia)	3._____
Artificial Joints (Knee, Hip)	Arthritis	_____
Anemia	Rheumatism	Additional Info: _____
Stroke	Cortisone Medication	_____
Kidney Trouble	Glaucoma	_____
Ulcers	Pain in Jaw Joints	4._____
Cosmetic Surgery	Cold Sores	_____
Sickle Cell Disease	Fever Blisters	Additional Info:_____
Hepatitis A (Infectious)	Hepatitis B (Serum)	_____
Liver Disease	Yellow Jaundice	_____
Blood Transfusion	Drug Addiction	5._____
Hemophilia	Venereal Disease (Syphilis, Gonorrhea)	_____
Epilepsy or Seizures	Herpes	Additional Info: _____
Fainting or Dizzy Spells	Nervousness	_____
ADD	Bruise Easily	_____
ADHD	Psychiatric Treatment	_____
Aspergers	Special Needs:	_____
Autism	_____	_____

IT IS IMPERATIVE THAT THE SECTIONS BELOW ARE COMPLETED!

DETAILED AND ACCURATE PATIENT AND FAMILY MEDICAL HEALTH HISTORY IS CRITICAL!

Are you immune suppressed? _____ yes _____ no
Have you ever-required long-term antibiotic therapy? _____ yes _____ no
Do you have frequent oral sores? _____ yes _____ no
Do you require steroid medications in conjunction with medical treatment? _____ yes _____ no

10. **Have you, the patient, ever been admitted to the hospital for any reason?** (i.e. broken bones, childbirth, etc.) List reason and date: _____
_____
_____
_____

11. **Have you, the patient, ever had surgery of any kind?** (i.e. appendectomy, previous oral surgery) Have you had any problems with a previous general anesthesia? (i.e. post operative nausea/vomiting, reaction to medication)
List procedure and date: _____
_____
_____
_____

12. In your **family medical history** (mother's or father's side of the family - up to the patient's grandparents) is there a history of major illness/disease? (i.e. heart attack or heart disease, high blood pressure, stroke, cancer, diabetes, etc.) List family member and illness/disease: _____
_____
_____
_____

13. FOR WOMEN ONLY:
Are you pregnant? _____ yes _____ no Due date? _____
Are you nursing? _____ yes _____ no
Are you taking birth control pills? _____ yes _____ no

THE ABOVE INFORMATION IS TRUE.

Patient/Guardian Signature:_____

CONSENT:

The undersigned hereby authorizes Dr. Duncan to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Duncan to make a thorough diagnosis of the patient's oral and maxillofacial needs. I also authorize Dr. Duncan to perform any and all forms of treatment, therapy and medication that may be indicated in connection with
(Name of patient)_____
and further authorize and consent that Dr. Duncan choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

_____

(Signature of Patient, Parent, Guardian, or Responsible Party)

_____

(Please print name of Patient, Parent, Guardian or Responsible Party)

_____ _____

Date **Relationship to Patient**

Revised 11/2014

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I, _____**(Patient Name or Parent/Guardian Name if Under 18)**, hereby acknowledge that I have been made aware of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. I have also been made aware that I may request a copy of this practice's Notice of Privacy Policy at any time.

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____ ☐ Written Communication

☐ O.K. to leave message with detailed information ☐ O.K. to mail to my home address
☐ Leave message with call-back number only ☐ O.K. to mail to my work/office address
☐ O.K. to fax to number indicated

☐ Work Telephone _____ ☐ Other (Fax/Cell, etc.) _____

☐ O.K. to leave message with detailed information _____
☐ Leave message with call-back number only

I allow you to give my clinical information to or answer questions from (check all that apply):

☐ Spouse
☐ Parent
☐ Child
☐ Other (specify): _____
☐ None

_____ _____
Patient or Parent/Guardian (if under 18) Signature Date

_____ _____
Print Name Birth date of **PATIENT**

Revised 4/11

Financial and Cancellation Policy

Dr. Dale R. Duncan
North Atlanta Oral & Maxillofacial Surgery

We are dedicated professionals providing the best possible care to our patients and we want you to completely understand our financial and cancellation policies.

Financial Policy

1. It is YOUR responsibility to contact your insurance company and find out whether or not we are a participating provider with your DENTAL insurance plan. We are contracted with many insurance companies to accept an assignment of benefits for our services. Even though we take most major dental insurance plans, we may not be on the type of plan that your company has selected. In order for us to file a claim with your insurance we will need for you to do the following:
    - **Ensure that you know your insurance benefits and whether or not we are a participating provider for your plan by calling your insurance carrier *PRIOR* to your appointment.**
    - **A valid insurance card must be presented at the initial consultation and any time thereafter if your insurance carrier changes**.
    - **Your deductible and co-pay portion is expected at the time of the consultation (if applicable) and at the time of surgery**. We accept CareCredit, Mastercard, Visa, Checks or Cash. We do NOT accept American Express or Discover.
2. As a courtesy we will file your insurance claim for you unless otherwise stated at the time of your consultation. ***You will be responsible for your deductible and co-insurance on the day of surgery.*** You will be billed for any amount not covered by your insurance carrier. **Payment is due upon receipt of your statement from our office.**
3. Please be advised that we are not a participating provider for any **medical** insurance plans. (Exception: Patients with Aetna DENTAL and MEDICAL…Aetna gives us IN Network privileges under Medical also.)
4. If you are insured by a plan that we are not a participating provider for, we will be happy to provide you with the necessary information (pre-op x-ray, ADA codes, etc.) in order for you to file with your insurance carrier**. Therefore payment is due at the time services are rendered.**
5. Our office will file with your ***Primary DENTAL*** policy only. If a secondary dental policy is in effect it is the patient's responsibility to independently file with any secondary policy(ies). We are happy to provide you with the necessary information (pre-op x-ray, ADA codes, ICD Diagnostic Codes, etc.) in order for you to file with your secondary. Please note: On the secondary claim form, be sure to mark claim reimbursement for benefits paid by this policy to the "subscriber" (patient) versus the "provider" (doctor). ***Any insurance checks issued to Dr. Duncan directly from a secondary insurance claim will be returned to the insurance company and it will be the patient's responsibility to contact their secondary to have the claim reprocessed and benefit payment reissued to the patient.***
6. **Divorced Parents of Patients** – The adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible to communicate with each other about treatment and payment issues.
7. We will work with your insurance company for 90 days to collect from your carrier; however, ***if we have not received payment within this 90 day time frame the balance owed on your account (PATIENT and/or INSURANCE) will be charged to the credit card on file***.
8. **Returned Checks** – Returned checks will incur a $25.00 service charge. Our office will only accept cash, certified funds or money order to cover the amount of the check plus the $25 service charge.
9. **Collection Fees** - The patient (or responsible party) is responsible for the final balance due after all insurance and patient monies have been applied. If your account is placed in collection status as a result of past due monies owed a $25 service charge will be added to your account before being turned over to our collection agency.

Cancellation Policy

Scheduling is a vital part of our practice and we work hard to ensure that we meet the needs of our patients.

1. We require a minimum of 24 hours cancellation notice if you are unable to make your *consultation* or *re-check* appointment. Adequate notice allows for us to offer the appointment to other patients who need to be seen. ***A $25 fee will be charged to any Consultation patient that fails to provide us with at least 24 notice of cancellation.***
2. Confirmation reminders from our office are a courtesy and it is the patient's responsibility to cancel any appointments.
3. To cancel or reschedule, please call our office during regular business hours as our after-hours call service cannot accept appointment related inquiries or calls.
4. ***Please note a $200 deposit is required to secure a surgical slot. This $200 fee will be applied to the patient's co-insurance amount due on surgery day. Any surgeries cancelled within this 48 hour (note - two BUSINESS days) timeframe will NOT be refunded this $200 Deposit Fee. Surgeries re-scheduled within the allowable timeframe per this cancellation policy will be either refunded or applied to a future surgical date.*** We maintain a surgical wait list; as well, our operating rooms (surgical trays, medications, etc.) are prepared ahead of time therefore it is imperative that surgical appointments are kept.

We reserve the right to amend our Financial Policy at any time. Please maintain a copy of this form for your records.

_____ _____

Patient's/Guardian's Signature **Date**

Rev. 01.2016