Patient Registration

Chesterfield Oral Surgery, Inc.
10110 Iron Bridge Road
Chesterfield, VA 23832
(804) 768-9000

Cellular Number _____

Emergency Contact # _____

Driver Contact # _____

PATIENT INFORMATION

NAME (Last)	FIRST	M.I.	NICKNAME	TITLE	DATE OF BIRTH

ADDRESS	APT	CITY	STATE	ZIP CODE	HOME PHONE	WORK PHONE	WORK EXT.

SOCIAL SECURITY NO.	SEX	MARITAL STATUS ❑ SINGLE ❑ WIDOWED ❑ MARRIED ❑ DIVORCED	STUDENT? SCHOOL

EMPLOYER	EMPLOYER ADDRESS

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE	GROUP ID

SUBSCRIBER NAME (Last, First, M.I.)

ADDRESS OF SUBSCRIBER

CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	DATE OF BIRTH

SOCIAL SECURITY #	INSURANCE I.D. NO.

EMPLOYER OF SUBSCRIBER

EMPLOYER ADDRESS

PRIMARY DENTAL INSURANCE	GROUP ID

SUBSCRIBER NAME (Last, First, M.I.)

ADDRESS OF SUBSCRIBER

CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	DATE OF BIRTH

SOCIAL SECURITY #	INSURANCE I.D. NO.

EMPLOYER OF SUBSCRIBER

EMPLOYER ADDRESS

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT: I authorize treatment of the person above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. A Finance Charge of 1.5% per month (18%) annually) will be made on accounts thirty days past due. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date.VIRGINIA LAW PERMITS PATIENT BILLING OF NON-COVERED SERVICES. INSURANCE COMPANIES DO NOT REGULATE FEES RELATED TO NON-COVERED MEDICAL OR DENTAL FEES. IF BILL QUESTIONS EXIST, PLEASE BE REMINDED YOU MUST PROVIDE WRITTEN DOCUMENTATION TO VALIDATE THE REASON FOR INQUIRY. _____

As a courtesy, this office will file most insurance claims for the patient. Anesthesia fees may or may not be a covered benefit under insurance. The patient assumes full responsibility for anesthesia and other non-covered fees. Should you have questions, please contact your carrier. It is the insured's responsibility to clarify exact benefits. Quoted insurance benefits are an estimate only. They do not imply or guarantee payment and coverage by the insurance company. If the insurance company does not pay, the bill becomes my responsibility for payment. All persons signed below are responsible for bill payment. UPON PATIENT REQUEST, WRITTEN PREAUTHORIZATIONS ARE AVAILABLE. _____

Insurance payments not received by this office within 90 days of service become my responsibility for payment. All proceeds of insurance are assigned to this office, but without them assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) Any portion of the bill not paid by insurance will become my responsibility for payment. Checks written in payment for this office that are returned will be assessed a $50.00 fee. This office does not participate with Southern Health Medical or United Healthcare Medical. This office does not make dentures, bridge work or replacement teeth._____

If unable to keep an appointment for surgery, I will call forty eight hours prior and cancel. Should I fail to do so and not appear for the scheduled surgery I will be assessed a $75.00 fee for wasted surgical supplies and personnel. _____

AGREEMENT: The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney and collection fees, not to exceed one-third of the unpaid balance and to pay all court costs incurred and/or collection costs including but not limited to credit reporting costs. _____

X_____ _____ _____/_____/_____

SIGNATURE OF THE PATIENT (OR PARENT) SS# DATE

X_____ _____ _____/_____/_____

SIGNATURE SS# DATE

PLEASE READ CAREFULLY AND ANSWER

Last Name | Address | Home Phone

First Name

Employer | Referred by | Age

PLEASE CIRCLE ANY CONDITION WHICH APPLIES OR HAS APPLIED TO YOU

Allergies	Prolonged Bleeding	Hepatitis
Heart Disease	Blood Transfusion	Glaucoma
Heart Murmur	Smoker	Dizzy Spells
Angina	Asthma	Fainting
Chest Pain	Bronchitis	Cancer
High Blood Pressure	Hay Fever	Radiation Therapy
Shortness of Breath	Emphysema	Chemotherapy
Swollen Ankles	Tuberculosis	Weight Loss
Artificial Heart Valve	Diabetes	Psych Therapy
Congenital Heart Defect	Ulcers	Implant Prosthesis
Rheumatic Fever	Kidney Disease	Anemia
Stroke	Liver Disease	Sickle Cell
Hemophilia	Thyroid Disease	Arthritis
Bruise Easily	Seizures	Other?

ANSWER YES OR NO FOR THE FOLLOWING QUESTIONS

1. WHAT IS THE NAME OF YOUR PHYSICIAN? _____
2. ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR DRUGS? LIST BELOW.
3. ARE YOU ALLERGIC TO PENICILLIN OR ANY MEDICINE OR DRUG?
4. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC?
5. HAVE YOU EVER BEEN ASLEEP FOR AN OPERATION?
6. IF YES, ANY COMPLICATIONS FROM THE ANESTHESIA?
7. HAVE YOU EVER BEEN TOLD NOT TO BE A BLOOD DONOR?
8. DO YOU USE TOBACCO? _____ PACKS SMOKED PER DAY.
9. WOMEN: ARE YOU PREGNANT? _____ MONTHS.
10. HAVE YOU EVER TAKEN STEROIDS?
11. DO YOU WEAR CONTACT LENSES?
12. DO YOU HAVE A HISTORY OF TMJ (TEMPOROMANDIBULAR JOINT) PROBLEMS?
13. HAVE YOU BEEN HOSPITALIZED IN THE PAST 5 YEARS?
14. DO YOU HAVE ANY DISEASES OR CONDITIONS NOT LISTED ABOVE?

SIGNATURE OF PATIENT (PARENT) _____ **DATE** _____

MEDICATIONS AND COMMENTS

Medication List:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

DR. STEPHEN C. BROWN, D.D.S.
ORAL and MAXILLOFACIAL SURGERY