Patient's Name: _____

Appointment Date: _____

Dear New Patient,

Welcome to our practice and thank you for giving us the opportunity to evaluate and manage your oral surgical needs. For your convenience, we are enclosing some forms and information to prepare you for your first visit.

Please complete the Registration Form and Medical Questionnaire, and read and sign the Financial Policy. In addition to those forms, you will need to bring your medical and/or dental insurance card(s). If you are a member of an HMO plan, a written referral or authorization is required and you are responsible for obtaining this. Contact your primary care provider (PCP) and have them fax the referral to our office at 713.793.1869 prior to the appointment date. You have the option of bringing the referral with you to your appointment; however, please be aware that without the referral we cannot file your insurance. This means that you would be responsible for payment of services.

A recent panorex, no older than six months, will be required for all temporomandibular joint (TMJ) evaluations and may be helpful for other types of consults, as well. If you have had a recent panorex, please have a copy forwarded to us prior to the appointment or bring it with you. If no panorex has been taken, indicate this to your PCP so they can include approval of the panorex on the referral or authorization.

Parking is available in our building, Scurlock Tower. The rate is determined by the amount of time you are parked in the garage and the maximum is $13. Valet parking is available at the same rate as the self-parking. We are unable to validate your parking, so please be prepared for this additional expense. Here is a quick review of all the things you will need to make your first visit go smoothly. We hope you find this helpful.

First Visit Checklist

- Registration Form Completed
- Medical Questionnaire Completed
- Financial Policy Read and Signed
- Medical or Dental Insurance Card(s)
- Referral or Authorization Faxed (If Member of HMO Plan)
- Copy of Panorex (If one has been taken in the last six months)

Like most health care practices, it is imperative that you arrive on time for your appointment. If you need to reschedule, please give 24-hours notice. If you have any other questions, please do not hesitate to contact us at 713.441.5577. Thank you again for this opportunity and we look forward to meeting you.

Sincerely,

Jaime Gateno, DDS, MD
Chairman
Oral and Maxillofacial Surgical Associates

Medical Questionnaire

Date:	**List any allergies and/or medications:**
What problems are you here for today?	

Past Medical History:
Please list any medical conditions may you have:

	Yes	No	Comments		Yes	No	Comments
Diabetes				Stomach or intestinal problem			
High blood pressure				Allergy problems			
Thyroid problems				Kidney problems			
Heart disease/cholesterol problems				Neurological problems			
Respiratory problems				Other medical diagnosis			
Bleeding disorder							

Please list any operations (and dates) you have ever had:

Please list any current medications (and amounts and times per day):
(Include aspirin, anti-inflammatory medications, antacids, hormone replacement, birth control, herbal supplements and over-the-counter medications)

Social History	Yes	No	Please list details below
Do you smoke? List how much.			
If no did you smoke previously?			
How often do you drink alcohol?			
How much?			
What is your occupation?			

Family history:

Please check the yes or no box to indicate whether any relatives have any of the following illnesses. If yes, please indicate which relative(s) have the problem

	Yes	No	
Heart problems			
Cleft lip/palate of craniofacial conditions			
Diabetes			
Cancer			
Bleeding disorder			
Anesthesia problems			
Others			

Referring Doctor Name: _____ **Phone:** _____

Review of Symptoms

Please check yes or no box to indicate if you have any of the following symptoms.
For any yes responses, please check the "current" box if this symptom relates to the reason for your visit today

	YES	NO	CURRENT		YES	NO	CURRENT		YES	NO	CURRENT		YES	NO	CURRENT
CONSTITUTIONAL				Abnormal bite				Apnea (stop breathing while sleeping)				**NEUROLOGICAL**			
Fatigue				Difficulty chewing				Wheezing				Headache			
Feeling sleepy during the day				Grinding or clenching teeth				**GASTROINTESTINAL**				Fainting			
Unexpected weight loss				Jaw pain				Difficulty swallowing				Weakness			
Fever				Speech problems				Pain on swallowing				Paralysis			
Chills				Face or neck swelling				Heartburn				Numbness			
Shakes				Sore throat				Abdominal pain				Seizures			
EYES				Toothache				Diarrhea				**PSYCHIATRIC**			
Decreased vision				Loose teeth				**MUSCULOSKELETAL**				Nervousness			
Double vision				Dry mouth				Jaw joint sounds				Tension			
EARS, NOSE, MOUTH AND THROAT				Mouth ulcers or blisters				Jaw popping out of socket				Depression			
Decreased hearing				**CARDIOVASCULAR**				Jaw locking				Anxiety			
Ringing of the ears				Chest pain or discomfort				Difficulty opening the mouth				**HEME/LYMPHATIC**			
Earaches				Palpitations				Jaw shifting on opening				Bleeding			
Nasal obstruction				Difficulty breathing				Jaw joint pain				Swollen glands			
Nasal drainage				Swollen ankles				Jaw swelling				**ALLERGIC/ INMUNOLOGIC**			
Nose bleeds				**RESPIRATORY**				Muscle pain				Rashes			
Mouth breathing				Difficulty breathing				Neck pain				Hives			
Food or drinks coming out of the nose				Snoring				Stiffness							

Height: _____ **Weight:** _____

FOR WOMEN ONLY

Are you using oral contraceptives (birth control pills)? Yes ☐ No ☐
There is evidence that certain antibiotics can reduce the efficacy of birth control pills. Patients taking antibiotics should use alternate methods of birth control to prevent pregnancy.
Are you currently trying to get pregnant? Yes ☐ No ☐
Surgery or anesthesia during early pregnancy can have serious consequences, including potential harm to the fetus.
Would you like to consult your physician to rule out pregnancy prior to having oral surgery? Yes ☐ No ☐

I have answered all the above to the best of my ability.

_____ **Date:** _____
Patient's Signature

PATIENT PHOTOGRAPH RELEASE

I give permission to the Houston Methodist Oral and Maxillofacial Surgical Associates and its authorized representatives to take and reproduce photographs in connection with my diagnosis, care and treatment, including surgical procedures, and authorize that such photographs may be part of the doctor's files or medical record. I also authorize the doctor to use and publish these photographs at his or her discretion for educational and research purposes, provided that I shall not be identified by name in any such publication use.

_____ **Date:** _____
Patient's Signature

Houston Methodist Oral and Maxillofacial Surgical Associates – Insurance Registration

Today's Date: _____

Patient's Last Name: _____ First Name: _____ MI: ___

Home Phone: _____ Cell: _____ Work: _____

Okay to leave message regarding health information on voicemail? If yes, initial box: ☐

Address: _____ Apt: _____ State: ____ ZIP: _____

Patient's SSN: _____ DOB: _____ Sex: _____

Marital Status: _____ E-mail Address: _____

If patient is 18 years or older and insured by parent: Is patient a student? Yes ☐ No ☐

If patient is a minor, parent's or guardian's full name: _____

Relationship: _____

Please tell us about your insurance coverage. Complete all fields:

1. MEDICAL INSURANCE

PRIMARY

Name of Insurance Company: _____
Policy Holder's Name: _____ SSN: _____ DOB: _____
Policy Holder's Employer: _____ ID No.: _____
Relationship to Patient: _____

SECONDARY

Name of Insurance Company: _____
Policy Holder's Name: _____ SSN: _____ DOB: _____
Policy Holder's Employer: _____ ID No.: _____
Relationship to Patient: _____

2. DENTAL INSURANCE

PRIMARY

Name of Insurance Company: _____
Policy Holder's Name: _____ SSN: _____ DOB: _____
Policy Holder's Employer: _____ ID No.: _____
Relationship to Patient: _____

SECONDARY

Name of Insurance Company: _____
Policy Holder's Name: _____ SSN: _____ DOB: _____
Policy Holder's Employer: _____ ID No.: _____
Relationship to Patient: _____

3. INJURY OR TRAUMA

Name of Workers Comp or Auto Ins. Company: _____
Case Worker's Name: _____ Claim No.: _____
Phone No.: _____ Employer: _____
Date of Injury: _____

I hereby assign insurance benefits to **Houston Methodist Specialty Physician Group (HMSPG)**. I authorize HMSPG to release any information necessary to secure the payment of benefits. I understand that if I have not furnished completely accurate insurance information at before the service is performed, HMSPG may refuse to accept assignment or re-file the claim with the correct carrier. I understand and agree that HMSPG will quote the benefits information received from the carrier and will use that information to estimate my portion; however, I am responsible for all charges (unless enrolled in a federally funded program or HMO).

_____ **Date:** _____

Patient or Parent/Guardian Signature

Financial Policy

We are pleased that you have chosen **Houston Methodist Specialty Physician Group** Oral and Maxillofacial Surgical Associates for the evaluation and management of your surgical needs. We hope that your experience here will be exceptional. We strive to communicate clearly and effectively with you in all aspects of your care. We have created this policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address those with the receptionist or office manager before you sign the acknowledgment.

1. **Forms of Payment:** Payment for services is expected the same day services are performed. For your convenience, we accept Visa, MasterCard and American Express, in addition to cash, checks, and money orders. You will be responsible for paying a $25 fee for returned checks.

2. **Insurance Benefits:** We will be happy to file your insurance claims as an added service to you. However, it is important that you understand that your insurance company does not share financial responsibility for your bill. Unless you are insured by a federal or state-funded program, you are responsible for all charges if your insurance company fails to pay.

3. **Preauthorizations and Precertifications:** You are responsible for obtaining authorizations from your PCP for office visits, when required by your insurance company. We will be happy to see you without the proper authorization but you will be required to pay for the visit. For surgeries or procedures to be performed by our doctors, we will attempt to get the service preauthorized. If the insurance company denies the service, we will notify you. If you have a question concerning your benefits, you should direct those to your insurance company.

4. **Patient Portion vs. Insurance Portion:** Before a service or surgery is performed, we will attempt to estimate the portion of the service that your insurance company will not cover. We will notify you of that portion either orally or in writing and you will be expected to pay your estimated portion on or before the service date. For procedures to be performed in the operating room, your estimated portion will be due on or before the preoperative visit.

As mentioned above, the insurance portion is estimated and is never a guarantee of payment even after an authorization has been obtained (except for state and federal funded programs). Ultimately, your bill is your responsibility regardless of insurance benefits.

5. **Denied or Unpaid Insurance Claims:** We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit payment within 120 days of the service date, you will responsible for the balance, unless you are insured by an HMO plan. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on a service, and our attempts to appeal the denial fail, you are responsible for the balance. Unfortunately, this sometimes happens even after the service has been preauthorized.

6. **Financial Arrangements:** In the event of financial hardship, optional payment arrangements may be discussed with the office staff before the planned date of the procedure or surgery. Since the doctor's main focus is on your health and treatment, they are unable to discuss fees or payment arrangements with you. If alternate arrangements are not requested and agreed upon before the date of the procedure, full payment of the patient's estimated portion will be due, as detailed in this policy.

7. **Cancellation of Appointments:** In fairness to other patients and the doctor, we require 24-hours notice if you must cancel an appointment. We reserve the right to charge a $25 fee for missed appointments without 24-hour notification.

8. **Parking:** Parking in the Sculock Tower is the patient's responsibility and we cannot validate your parking ticket. The amount charged is determined by time spent in the garage, with a maximum charge of $13.

Thank you again for entrusting us with your care. If you have any questions about this policy or something not addressed in the policy, do not hesitate to ask a member of our office staff.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all dental, medical and/or surgical benefits to **Houston Methodist Specialty Physician Group** Oral and Maxillofacial Surgical Associates and authorize the release of medical information to insurance company(s), when requested or necessary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original.

AGREEMENT WITH FINANCIAL POLICY

I have read and agreed to the above financial policy. I understand that I am ultimately responsible for all fees for services provided to me.

_____

Patient's Name (Printed)

_____ **Date:** _____

Patient or Responsible Party's Signature

_____

Printed Name of Signer, If Different from Above

Please visit **houstonmethodist.org/locations/hospitals** for directions to the **Texas Medical Center.**

Houston Methodist Oral and
Maxillofacial Surgical Associates

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HOUSTON Methodist® LEADING MEDICINE