Office (701) 707- 3720
Fax (701) 707-3727

Patient Information Profile

Patient's Name: _____ Today's Date: ___/___/___
Last First MI

Date Of Birth: ___/___/___ Age: _____ Social Security No: _____

Male / Female (Circle One) Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ - _____ - _____ Home Cell (circle one)

Secondary Phone: (if applicable) _____ - _____ - _____ Home Cell Work (circle one)

Patient Employer: _____ Referring Dentist: _____

If the patient is a minor, please provide the following information:

Mother's Name: _____ Mother's Phone: _____

Father's Name: _____ Father's Phone: _____

Lives with: Mother Father Both (circle one) Other, please explain: _____

Responsible Party: (if different from patient or if patient is a minor)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact:

Name: _____ Relationship to patient _____

Phone Number (s): _____

Insurance Information:

PRIMARY DENTAL INSURANCE:
Name of Insurance Co:_____ Claims Phones Number:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Date of Birth:____/____/____
Policy Holder's Employer:_____ Plan ID or SS#:_____

SECONDARY DENTAL INSURANCE:
Name of Insurance Co:_____ Claims Phones Number:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Date of Birth:____/____/____
Policy Holder's Employer:_____ Plan ID or SS#:_____

PRIMARY MEDICAL INSURANCE:
Name of Insurance Co:_____ Claims Phones Number:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Date of Birth:____/____/____
Policy Holder's Employer:_____ Plan ID or SS#:_____

SECONDARY MEDICAL INSURANCE:
Name of Insurance Co:_____ Claims Phones Number:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Date of Birth:____/____/____
Policy Holder's Employer:_____ Plan ID or SS#:_____

If Accident Related ONLY:

Name of Insurance Co:_____ Claims Phones Number:_____
Insurance Address:_____ City:_____ State:_____ Zip:_____
Policy Holder's Name:_____ Date of Birth:____/____/____
Date of Injury:_____ Description:_____ Plan ID or SS#_____

Please note, it is the patient and/or guardian's responsibility to inform us of all insurance coverage. We are not contracted with Medicare or Medicaid, which means claims are not able to be filed to those insurance companies. We are in-network providers for both Blue Cross Blue Shield and Delta Dental. Please call if you have any questions regarding your insurance or coverage.

Financial Policy – Anew Oral Surgery

Thank your for choosing Anew Oral Surgery

Thank you for choosing Anew Oral Surgery as your healthcare provider. We are grateful that you are entrusting your care to us. Please understand that payment of your bill is considered part of your treatment experience. The following is a statement of our financial Policy. We require that you read and sign your agreement.

You Are Responsible for Your Bill

As the recipient of our services, you are responsible for the charges associated with each of the services your received during your treatment. You (or your guardian, if you are a minor), must pay for the services you receive from our office. Many patients have insurance, financial support from family members, who pay all or a portion of your bill on your behalf, but you remain responsible for your bill.

Payment for Our Services is Due on the Day You Receive Services

Payment for our services is due on the day you receive the services. If you have no insurance, the entire amount of your bill will be due on the day of your appointment. If this amount is difficult for you to pay out of pocket on the day of your appointment, we accept Care Credit as a financing option. We are unable to finance your treatment through our office. You cannot pay your bill "over time" or "on account" through our office. We would be happy to help you obtain financing for our services before treatment is rendered through Care Credit. We also accept Visa, Mastercard and Discover.

If You Have Insurance

If you have dental or medical insurance, we will assist you in receiving the maximum allowable benefits available under your insurance policies. We will fire a claim for services on your behalf, and in many cases we can receive some payment directly from your insurance company. By signing this form, you authorize payment directly to Anew Oral Surgery for all insurance benefits otherwise payable to you for services rendered to you or on behalf of your dependents. However, you remain responsible for your bill, not your insurance company. **If, after 60 days, we are unable to receive payment for services on your behalf after following normal claim submission procedures, we will except payment in full from you.**

We Will Collect the Estimated Amount You Will Owe at Your Appointment

Depending on your insurance, we will collect on the day of your appointment the amount estimated to be your responsibility. We determine this amount by estimating the services and charges we think you may receive and then subtract the amount we believe your insurance company may pay on your behalf (based on the insurance information given to us). We then ask you pay the remainder on the day you receive services. You may require additional services (or fewer services), in which case your charges may be greater or less than our estimate. **Please keep in mind that this is only an estimate and we cannot pre-determine the exact services you will require or guarantee the final payment amount form your insurance companies.**

Questions? Please Ask Our Staff

Our staff is trained to answer your questions regarding your bill and payment arrangements. We do our best to stay on top of insurance plans and would be happy to help you try to understand all of the confusing details and provisions found in many plans. We don't mind talking about money and bills, so please, feel comfortable discussing our charges and your bill.

"I have read and understood this Financial Policy, agree to its provisions, and accept responsibility for this account."

Signed _____ **Date** _____

Patient *(or Parent/Guardian, if minor)*

Release of Information for Routine Care & Notice of Privacy Practices

The following release will allow us to share pertinent information regarding your care to enhance your treatment and / or financial reimbursement for services received:

1. I authorize Anew Oral Surgery to share information regarding my course of treatment and the services received with my referring medical and dental providers in order to enhance my continuing treatment and care.

2. I authorize Anew Oral Surgery and/or any other medical provider or supplier of services in this office to release any information required to secure payment of the benefits on my behalf. I authorize the use of his signature on all insurance submissions.

3. I have had the opportunity to review this office's Notice of Privacy Practices.

Signed: _____ Patient/or Guardian if minor Date: _____

Please check your preferred means of communication (you may check more than one)

- ○ You may contact me at my home telephone number: _____
- ○ You may contact me on my mobile telephone number: _____
- ○ You may contact me on my work telephone number: _____
- ○ You may send me an email at: _____
- ○ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) ***in addition to*** custodial parents and legal guardians:

1. _____ Phone: _____ Date added/removed: _____

2. _____ Phone: _____ Date added/removed: _____

3. _____ Phone: _____ Date added/removed: _____

Patient Medical History

Patient Name:_____Age:_____Weight:_____Height:_____

Primary Medical Doctor:_____Clinic Name/Location_____

Pharmacy:_____

***Past and Present* Medical History: Please check (X) the box next to any illness or problem that applies to you**

○ AIDS/HIV Positive	○ Chemotherapy	○ Mitral Heart Valve Disease	○ Psychiatric Care
○ Alzheimer's/Dementia	○ Congenital Heart Disorder	○ Heart Pacemaker	○ Radiation Treatments
○ Anaphylaxis	○ Congestive Heart Failure	○ Heart Trouble/Disease	○ Renal Dialysis
○ Anemia	○ Cortisone/Steroid Treatment	○ Hepatitis A, B, C	○ Rheumatic Fever
○ Angina or Chest Pain	○ High Cholesterol	○ Hiatal Hernia	○ Sinus Trouble
○ Anxiety	○ Depression	○ High Blood Pressure	○ Stomach/Intestinal Disorder
○ Arthritis/Gout	○ Diabetes	○ Hypoglycemia	○ Stroke
○ Artificial Heart Valve	○ COPD/Emphysema	○ Irregular Heartbeat	○ Swelling of Limbs
○ Artificial Joint	○ Epilepsy/Seizures	○ Kidney Disease	○ Thyroid Disease
○ Asthma	○ Fainting/ Dizziness	○ Leukemia	○ Tuberculosis
○ Blood Disease	○ Heartburn/GERD (reflux)	○ Liver Disease	○ Ulcers
○ Bleeding Disorder	○ Glaucoma/Eye Disease	○ Low Blood Pressure	○ Yellow Jaundice
○ Birth Defect	○ Heart Attack	○ Lung Disease	○ Other
○ Cancer	○ Heart Murmur	○ Pain in Jaw Joints	

History of Surgeries/Procedures:

Reason for Hospitalization or Outpatient Surgery	***Date:***

YES or NO Do you use tobacco products? If yes, how much per day/type?_____

YES or NO Are you required by a physician to take antibiotics prior to dental appointments?_____

YES or NO Do you take a medication that is a blood thinner? Please list:_____

YES or NO Have you or a family member had Malignant Hyperthermia?_____

YES or NO Have you had any previous problems with anesthesia?_____

Women: Are you pregnant? **YES or NO** Are you nursing? **YES or NO** Are you taking oral contraceptives? **YES or NO**

Please list all current medication including over the counter medications or supplements:

Please list ALL ALLERGIES to medications, latex, metals, products, food or the environment:

"I understand the importance of providing a truthful medical history to assist my doctor in providing the best care possible. I certify that the information provided here is accurate and complete, and that I will ask questions of my doctor and assisting staff to clarify any items I do not understand."

Patient/Guardian Signature_____Todays Date:_____