HENRY N. AMBROOKIAN, JR., D.D.S.
ORAL & MAXILLOFACIAL SURGERY

NOTE: New patients must complete all lines of the registration, financial policy and medical history forms. HIPAA , Wisconsin law and the Wisconsin Dental Association permit Doctors to request and obtain the following personal identifying information, which we may use and disclose to carry out treatment, insurance and payment activities , account collection and healthcare operations. This is a condition of treatment by us. If you do not provide this information, we may decline to treat you. Thank you for your understanding.

PATIENT INFORMATION:

NAME _____ **BIRTHDATE**_____

First M.I. Last

SEX: M F MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOW

ADDRESS_____**SS#**_____

CITY _____STATE_____ZIP_____ **TELEPHONE** ( )_____

DRIVER'S LICENSE # _____**EXP**._____ **CELLULAR** ( )_____

EMPLOYER / SCHOOL_____ OCCUPATION_____ PART / FULL

EMPLOYER'S / SCHOOL'S CITY_____TELEPHONE ( )_____

WHOM MAY WE THANK FOR REFERRING YOU ? _____

HAVE YOU BEEN A PATIENT IN OUR OFFICE BEFORE ? YES NO WHAT YEAR ? _____

ACCOUNT INFORMATION :

INSURANCE HOLDER'S NAME_____RELATIONSHIP_____**DOB**:_____

ADDRESS (If Different) _____**SS#** _____

CITY _____STATE _____ZIP_____ **TELEPHONE** ( )_____

CELLULAR ( )_____

EMPLOYER _____OCCUPATION_____

EMPLOYER'S CITY_____ TELEPHONE ( )_____

SPOUSE'S / EX-SPOUSE'S / PARENT'S NAME _____**DOB**:_____

ADDRESS (If Different)_____**SS#** _____

CITY _____STATE_____ZIP_____**TELEPHONE ( )**_____

CELLULAR ( ) _____

SPOUSE'S / EX-SPOUSE'S / PARENT'S EMPLOYER_____ OCCUPATION_____

EMPLOYER'S CITY _____ TELEPHONE ( ) _____

INSURANCE INFORMATION: (PLEASE CIRCLE " YES " or " NO " AND PROVIDE INSURANCE CARDS)

DENTAL INSURANCE ? YES NO MEDICAL INSURANCE ? YES NO

SECONDARY DENTAL INSURANCE ? YES NO SECONDARY MEDICAL INSURANCE ? YES NO

FINANCIAL POLICY

EXAMINATION / CONSULTATION: Before treatment is rendered , each patient will be examined and xrays, if necessary will be taken. The fee for examination/consultation and xrays is separate and in addition to the fee for treatment. Some insurance plans provide benefits for these services, while others do not. **Most dental insurance plans place limitations on the number of examinations allowed per year. Some medical plans only cover the examination/consultation if a covered surgical procedure is performed on the same day.**

FEES: Our fees are set at a level to maintain quality service and may be lower or higher than other oral surgery practices. The fee for intravenous sedation varies and is based on time and duration of anesthesia. Insurance companies have established fee schedule limitations which are designed to reduce their liability for claim payment. Each company's fee schedule is unique and our fees may not be the same as your insurance company's "usual and customary" allowance. Therefore, all fees may not be completely paid. Some services may not be a covered benefit or your insurance company may claim the treatment is medically unnecessary according to their guidelines. This is due to your contract limitation and designed to reduce the insurance company's liability for benefit payment. We view all of this as an issue between you and your insurance carrier.

INSURANCE: We strongly encourage you to know your insurance benefits and rules. Whenever possible, we will obtain a verbal verification of insurance benefits for you as a courtesy. This is only an estimate of benefits available based on information the insurance company gives our office on the specific date we request it. It is not a guarantee of benefits and may change due to a number of factors. We will submit your claim for you as a courtesy providing we hold an assignment of benefits signed by you. After 60 days, if payment has not been received , you will be responsible for payment of your bill in full. Delayed insurance payments do not relieve your obligation to pay balances when due. If an insurance payment for services rendered is sent directly to me/the subscriber instead of to Dr. Ambrookian, I will send Dr. Ambrookian payment in full of the amount paid/sent to me/the subscriber by my insurance company, within seven (7) days of my receipt of this payment. Otherwise, my account will be considered delinquent, past due and become immediately due and payable in full.

MEDICARE / MEDICAID (Title19): Medicare **does not** cover dental services or services related to the care, removal or replacement of teeth or their supporting structures. Dr. Ambrookian is **not a** Medicare or Medicaid provider and **can not submit claims to Medicare or Medicaid.** Therefore, you are personally responsible for payment of your entire bill at the time services are rendered.

PAYMENT: Fees for examination / consultation, services not covered by insurance, remaining deductibles for primary and secondary (if applicable) medical and dental insurance, and coinsurance (if benefits have been predetermined) are due and payable in full at the time of service. An outstanding balance for previous treatment/surgery must be paid prior to any new services, treatment or surgery. If you have a "direct reimbursement" insurance plan (i.e.- payment of insurance benefits are sent directly to the patient instead of the doctor), payment in full is due at the time services are rendered. Depending upon your insurance benefits, a partial payment may be required at the time of surgery. If we are unable to verify your insurance benefits, payment in full is due at the time services are rendered. Payment can be made by cash, check, Mastercard or Visa. There is a charge for returned checks. A billing statement is mailed monthly and will only be sent to the financially responsible person(s) whose signature is below. We can not bill another "designated" financially responsible person (i.e.- spouse, ex-spouse, other parent , step-parent, relative, friend, legal guardian/Power of Attorney or partner) unless his/her signature is on this form.

I authorize the release of information for the purpose of insurance benefits and irrevocably assign payment directly to Henry N. Ambrookian, Jr., D.D.S., of the insurance benefits otherwise payable to me. I understand that I am personally responsible for payment of **all** charges, including those not covered by insurance, any balance not paid by my insurance, copayments, deductibles and any amounts in excess of my insurance carriers "usual and customary" limitation. If this account becomes delinquent, I will pay all costs of collection, including court costs, attorney's fees and / or collection agency commissions or fee. I certify that I speak, read, write and understand English.

Signature Financially Responsible Person_____ Date_____

Signature Financially Responsible Person_____ Date_____

Name (Please Print) _____Relationship_____

Birth Date _____ Social Security # _____

Driver's License # _____ State _____ Expires_____

_

WITNESS _____

MEDICAL HISTORY

PATIENT NAME _____ SEX: M F BIRTHDATE _____

REASON FOR YOUR DENTAL VISIT TODAY: _____

ARE YOU IN GOOD HEALTH ? YES NO WHEN WAS YOUR LAST PHYSICAL EXAM ? _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN ? YES NO

IF YES, FOR WHAT ? _____

ARE YOU TAKING ANY PRESCRIPTION MEDICATION ? YES NO

IF YES, WHAT ? _____

HAVE YOU HAD ANY OPERATIONS OR EVER BEEN HOSPITALIZED ? YES NO WHEN ?_____

PLEASE EXPLAIN :_____

ARE YOU TAKING ANY HERBAL MEDICATIONS OR SUPPLEMENTS ? YES NO

IF YES, WHAT ? _____

ARE YOU ALLERGIC TO ANY MEDICATION ? YES NO

PLEASE EXPLAIN:_____

ARE YOU TAKING ANY BLOOD THINNERS ? (COUMADIN / WARFARIN, PLAVIX, ASPIRIN) YES NO

NAME OF PERSONAL PHYSICIAN_____ TELEPHONE: ( ) _____

PERSON TO NOTIFY IN AN EMERGENCY_____ RELATIONSHIP_____

ADDRESS: _____ TELEPHONE: Home ( )_____Work ( )_____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ? (PLEASE CIRCLE YES OR NO)

Attention Deficit Disorder / ADD / ADHD	YES	NO	SLEEP APNEA	YES	NO
RHEUMATIC FEVER	YES	NO	REACTION TO DENTAL (LOCAL) ANESTHETIC	YES	NO
Heart Attack / Heart Disease / Congestive Heart Failure	YES	NO	LATEX OR RUBBER ALLERGY	YES	NO
HEART MURMUR / ABNORMAL HEART SOUND	YES	NO	ANXIETY, PANIC ATTACKS, NERVOUS DISORDER	YES	NO
IRREGULAR HEART BEAT	YES	NO	CANCER	YES	NO
HEART OR BYPASS SURGERY	YES	NO	SHORTNESS OF BREATH AFTER MILD EXERCISE	YES	NO
PACEMAKER	YES	NO	STOMACH ULCER, HYPERACIDITY, ACID REFLUX	YES	NO
HIGH OR LOW BLOOD PRESSURE	YES	NO	RADIATION OR CHEMOTHERAPY	YES	NO
ANEMIA	YES	NO	FREQUENT OR RECURRING MOUTH SORES	YES	NO
BLEEDING DISORDER / PROBLEMS	YES	NO	DEPRESSION / PSYCHIATRIC TREATMENT	YES	NO
BLOOD TRANSFUSION	YES	NO	PERSISTENT SWOLLEN ANKLES OR NECK GLANDS	YES	NO
ORGAN TRANSPLANT _____	YES	NO	DRUG, ALCOHOL ABUSE OR ADDICTION	YES	NO
GLAUCOMA	YES	NO	TUBERCULOSIS	YES	NO
ARTHRITIS – RHEUMATOID, OSTEOARTHRITIS	YES	NO	EXPOSURE TO THE AIDS VIRUS OR HIV +	YES	NO
DIABETES	YES	NO	VENEREAL OR SEXUALLY TRANSMITTED DISEASE	YES	NO
ASTHMA, HAYFEVER, SEASONAL ALLERGIES	YES	NO	DO YOU WEAR CONTACT LENSES ?	YES	NO
HEPATITIS, JAUNDICE OR LIVER DISEASE	YES	NO	DO YOU SMOKE OR CHEW TOBACCO?	YES	NO
STROKE	YES	NO	Have you ever been treated for osteoporosis ?	YES	NO
KIDNEY DISEASE OR STONES	YES	NO	Are you being treated with medication for any other bone disease or cancer?	YES	NO
ARTIFICIAL JOINT (Where ? _____)	YES	NO			
IMPLANTS (Where ? _____)	YES	NO	Have you ever taken or are you taking any of the following Medications: Aredia (pamidronate), Zometa (zolendronic), Actonel (risendronate), Fosamax (alendronate), Boniva?	YES	NO
Temporomandibular Joint (TMJ) Problems	YES	NO			
CHEST PAIN OR ANGINA	YES	NO			
THYROID DISORDER	YES	NO	**FEMALES:**		
SINUS PROBLEMS	YES	NO	ARE YOU OR MIGHT YOU BE PREGNANT ?	YES	NO
EMPHYSEMA OR BRONCHITIS	YES	NO	ARE YOU CURRENTLY USING BIRTH CONTROL?	YES	NO
EPILEPSY OR SEIZURES	YES	NO	ARE YOU NURSING?	YES	NO
FAINTING SPELLS	YES	NO	**IS THERE ANYTHING ELSE THE DOCTOR SHOULD BE AWARE OF**	YES	NO

_____

SIGNATURE_____ DATE_____ WITNESS_____

(Patient if age 18 or older, Parent or Legal Guardian)

Reviewed By Doctor Date

HENRY N. AMBROOKIAN, JR., DDS

ORAL & MAXILLOFACIAL SURGERY

WISCONSIN CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: INDIVIDUAL GIVING CONSENT (Please Print)

Patient Name: _____ Date of Birth: _____ Soc. Sec. #_____

SECTION B: PATIENT / PARENT / LEGAL GUARDIAN / PERSONAL REPRESENTATIVE - PLEASE READ AND COMPLETE THE FOLLOWING.

Purpose of Consent: By signing this form, you will give written permission under Wisconsin law to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. This Consent is a condition of treatment by us. If you decide not to sign this Consent, we may decline to treat you. You may revoke this Consent at any time by giving us written notice. Revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and we may decline to treat you or continue treating you if you revoke this Consent.

DISCLOSURE OF HEALTH INFORMATION BETWEEN PHYSICIANS / DENTISTS TAKING CARE OF THE SAME PATIENT IS NOT RESTRICTED.

Family and Friends: I consent to allow you to disclose my health information to the following individual(s):

Insurance / benefit / payment information may be disclosed to or discussed with my:

(Please Initial): _____ Spouse _____ Mother _____ Father _____ Other / Friend(s) _____

Appointment information may be disclosed to or discussed with my:

(Please Initial): _____ Spouse _____ Mother _____ Father _____ Other / Friend(s) _____

Diagnosis / treatment information may be disclosed to or discussed with my:

(Please Initial): _____ Spouse _____ Mother _____ Father _____ Other / Friend(s) _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Appointment Reminders / Instructions: I consent to allow you to use or disclose my health information to provide me with appointment reminders (using voicemail, messages, answering machines, postcards, or letters) and appointment instructions (such as a reminder to bring xrays, your insurance information, take necessary medication or antibiotic premedication and instructions for intravenous anesthesia).

(Please Initial): _____ Yes _____ No

You may call me: at home: **(Please Initial):** _____ Yes _____ No at work: **(Please initial)** _____ Yes _____ No

Duplicate X-Ray: If requested by my referring, current or treating dentist and/or physician, you may send a duplicate x-ray to him/her:

(Please initial): _____ Yes _____ No

I, _____, have had full opportunity to read and consider the contents of this Consent form and your
(Name - Please Print)

Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ **Date:** _____
(Patient - if age 18 or older, Parent, Legal Guardian or Personal Representative)

Relationship to Patient : _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.