PATIENT NAME:	



## YOUR INFORMATION

FULL LEGAL NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
EMAIL ADDRESS:		
CELL PHONE:	HOME PHONE:	
DATE OF BIRTH:		
SOCIAL SECURITY NUMBER:		
GENDER: MALE / FEMALE / NON-BINARY / TR	RANSGENDER	
MARITAL STATUS: SINGLE / MARRIED / DIVO	RCED/WIDOWED	
EMPLOYMENT STATUS: FULL TIME / PART TIME	ME / RETIRED EMPLOYER:	
STUDENT STATUS: FULL TIME / PART TIME		
NAME OF SCHOOL: RETURNING PATIENT: YES	S/NO	
DENTIST OR PROVIDER WHO SENT YOU TO O	OUR OFFICE TODAY:	
YOUR	R EMERGENCY CONTA	ACT
NAME:	PHONE NUM	_
RELATIONSHIP TO PATIENT:		
YOUR TRUSTED PERSON FOR I		
When required, I permit Wood & Myers to provi		-
RELATIONSHIP TO PATIENT:		

PATIENT NAME:	



## YOUR HEALTHCARE PROVIDERS AND INSURANCE COVERAGES

1. GENERAL DENTIST/ PRACTICE NAME:		
ADDRESS / PHONE NUMBER:		
2. MEDICAL PHYSICIAN NAME		:
ADDRESS / PHONE NUMBER:		
3. SPECIALIST NAME:		
ADDRESS / PHONE NUMBER:		
4. PREFERRED PHARMACY:		
LOCATION / PHONE NUMBER:		
5. PREFERRED LABORATORY:		
LOCATION / PHONE NUMBER:		
DENTAL INSURANCE		
DENTAL INSURANCE COMPANY NAME:		
TELEPHONE NUMBER:		
NAME OF POLICY HOLDER/SUBSCRIBER:		
POLICY HOLDER EMPLOYER:		
POLICY OR ID NUMBER:		
MEDICAL INSURANCE		
MEDICAL INSURANCE COMPANY NAME:		
TELEPHONE NUMBER:		
NAME OF POLICY HOLDER/SUBSCRIBER:		
POLICY HOLDER EMPLOYER:		
POLICY OR ID NUMBER:	GROUP NUMBER:	



# MEDICAL HISTORY

HEIGHT	PREVIOUS SURGERIES OR SERIO	US ILLNESSES
WEIGHT		
CARDIOVASCULAR SYST	ЕМ	
Y N  ARE YOU CURRENTLY UNDER THE C	ARE OF A	HEART PALPITATIONS OR FLUTTER
CARDIOLOGIST?  IF YES, NAME OF CARDIOLOGY PRACTICE:		HIGH BLOOD PRESSURE  RHEUMATIC FEVER  OTHER HEART OR VESSEL DISEASE  IF YES, PLEASE DESCRIBE:
MITRAL VALVE PROLAPSE CHEST PAIN, ANGINA HEART ATTACK OR STROKE		
PULMONARY SYSTEM		
Y N  ASTHMA  BRONCHITIS (PAST 3 MONTHS)  CHRONIC OBSTRUCTIVE LUNG DISEA  EMPHYSEMA  SHORTNESS OF BREATH  SLEEP APNEA		PNEUMONIA (PAST 3 MONTHS)  PRODUCTIVE COUGH  NASAL CONGESTION  NOSE BLEEDS  SMOKING / TOBACCO PRODUCTS  IF YES, FOR HOW LONG:
WOMEN Y N	Υ	N
ARE YOU PREGNANT OR PLANNII		ARE YOU NURSING?
GASTROINTESTINAL		
Y N  GASTROESOPHAGEAL REFLUX DISEA  COLITIS CROHN'S DISEASE	ASE T	N IRRITABLE BOWEL SYNDROME OTHER IF YES, PLEASE DESCRIBE:





# **OTHER**

Υ	N		Y N	
		ANEMIA		ARE YOU PRESENTLY UNDER A DOCTOR'S CARE FOR ANY REASON?  IF YES, PLEASE DESCRIBE:
		JAUNDICE		
		HEPATITIS		HAVE YOU OR A BLOOD RELATIVE HAD SERIOUS COMPLICATIONS WITH GENERAL ANESTHESIA? IF YES, PLEASE DESCRIBE:
		MONONUCLEOSIS (MONO)		
		DIABETES		HAVE YOU HAD A PROBLEM WITH LOCAL ANESTHESIA?
		THYROID DISEASE		IF YES, PLEASE DESCRIBE:
		SEIZURES / EPILEPSY / CONVULSIONS		DO YOU USE ALCOHOL? IF YES, HOW MUCH:
		GLAUCOMA	шШ	DO TOO USE ALCOHOL: II TES, HOW MOCH.
		FAINTING EPISODES		DO YOU USE MARIJUANA AND/OR RECREATIONAL DRUGS? IF
		BLEEDING PROBLEMS		YES, HOW MUCH:
		VENEREAL OR AIDS DIAGNOSIS		
		BLOOD TRANSFUSION		HAVE YOU HAD RADIATION TREATMENTS?  IF YES, PLEASE DESCRIBE DATE, AREA AND AMOUNT OF RADIATION:
		TUBERCULOSIS		
		EMOTIONAL / MENTAL HEALTH PROBLEMS		DO YOU HAVE ANY DISEASE, DRUGS OR TRANSPLANT
		MOTION SICKNESS		OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM?
		KIDNEY DISEASE		ARE YOU TAKING ANY MEDICATIONS FOR DIABETES OR
		SICKLE CELL DISEASE		WEIGHT LOSS SUCH AS TRULICITY, OZEMPIC, SEMAGLUTIDE, VICTOZA, PHENTERMINE OR OTHER MEDICATION?
		MUSCULAR DISEASE		ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BONE DENSITY
		PARKINSON'S DISEASE		MEDS OR BISPHOSPHONATES SUCH AS FOSAMAX, ACTONEL, IV-ZOMETA, AREDIA, XGEVA, PROLIA, OR RECLAST BONIVA, IN
		WEAR CONTACT LENSES / GLASSES		THE PAST 12 IN YEARS?
		TMJ		HAS A PHYSICIAN OR PREVIOUS DENTIST RECOMMENDED THAT
		SURGICAL JOINT REPLACEMENTS		YOU TAKE ANTIBIOTICS PRIOR TO YOUR DENTAL TREATMENT? IF YES, FOR WHAT REASON:
		OSTEOPOROSIS / OSTEOPENIA		
		IS THERE ANYTHING LOOSE OR REMOVEABLE IN YOUR MOUTH I.E. LOOSE TOOTH, DENTURES, RETAINERS, TONGUE JEWELRY, ETC?		IS THERE ANY OTHER CONDITION NOT LISTED ON THIS FORM THAT YOU FEEL WE SHOULD BE MADE AWARE OF? IF YES, PLEASE DESCRIBE:
		HAVE YOU HAD A CONCUSSION IN THE PAST YEAR? IF YES, DATE AND MEDICAL ISSUES/RESTRICTIONS:		



## **DIABETIC/ WEIGHT LOSE MEDS/ GLP-1**

ΥN		ΥN	
	DULAGLUTIDE (TRULICITY)		SEMAGLUTIDE (WEGOVY, OZEMPIC, RYBELSUS)
	LIRAGLUTIDE (VICTOZA OR SAXONDA)		TIRZEPATIDE (MONJARO, ZEPBOUND)
	LIXISENATIDE (ADLYXIN)		PHENTERMINE
	EXENATIDE (BYDUREON)		EXENATIDE EXTENDED RELEASE (BYDUREON BCISE)
	I CONFIRM I DO $\underline{NOT}$ Take any of the medications listed above		
ORAL	L DIABETIC/SGL-2		
<u>Y</u> <u>N</u>		ΥN	
	DAPAGLIFLOZIN (FARXIGA)		EMPAGLIFLOZIN (JARDIANCE)
	ERTUGLIFOZIN (STEGLARTRO)		CANAGLIFLOZIN (INVOKANA)
ШШ	CANAGLIFLOZIN/METFORMIN (INVOKANAMET)		EMPAGLIFOZIN/LINAGLIPTIN (GLYXAMBI, QTERN)
	EMPLAGLIFOZIN/METFORMIN (SYNJARDY)		DAPAGLIFLOZIN/METFORMIN (XIGDUO)
	IPRAGLIFLOZIN (SUGLAT)		TOFOGLIFLOZIN (APLEWAY/DEBERZA)
	SOTAGLIFLOZIN (INPEFA)		ERTUGLIFLOZIN/METFORMIN
	I CONFIRM I DO <u>NOT</u> TAKE ANY OF THE MEDICATIONS LISTED ABOVE		
ALLE	RGIES		
Y N	ARE YOU ALLERGIC TO LATEX OR RUBBER PRODUCTS?	Y N	ARE YOU ALLERGIC TO LOCAL ANESTHETIC OR NUMBING MEDS?
	ARE YOU ALLERGIC TO SOY PRODUCTS OR EGGS?		ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE
	THE TOO NEEDING! O' TO SO'! HODGE! DON' EGGS.		LIST:
	CATIONS LIST ALL MEDICATIONS YOU ARE TAKING BELO		E INCLUDE PRESCRIPTION, NON-PRESCRIPTION,
HOMEOPA	THIC OR HERBAL, INHALERS, INJECTIONS, OR RECREATIONAL DRU	us.	
NAME OF	MEDICATION DOSAGE		CONDITION



TIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWL NQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I W BER OF HIS / HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I	/ILL NOT HOLD MY DOCTOR, OR ANY OTHER
SIGNATURE	DATE
(COMPLETED BY STAFF ONLY)	
SIGNATURE OF PERSON REVIEWING HEALTH HISTORY	DATE
SIGNATURE OF PERSON REVIEWING HEALTH HISTORY	DATE
SIGNATURE OF PERSON REVIEWING HEALTH HISTORY	DATE



**SIGNATURE** 

### INSURANCE POLICY

IF YOU HAVE INSURANCE, WE CAN ASSIST YOU IN SUBMITTING YOUR CLAIM. YOUR INSURANCE CLAIM WILL ONLY BE COMPLETED AND SUBMITTED IF WE ARE PROVIDED WITH ALL PERTINENT INSURANCE COMPANY INFORMATION. IT IS YOUR RESPONSIBILITY TO VERIFY THAT YOUR POLICY IS IN EFFECT AT THE TIME YOUR SERVICES ARE RENDERED. YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. WE MAY NOT BE AWARE OF YOUR SPECIFIC INSURANCE PLAN LIMITATIONS WHICH MAY RESULT IN A PAYMENT THAT DIFFERS FROM OUR ESTIMATED OR ACTUAL COST OF TREATMENT SUCH AS:

- MISSING TOOTH CLAUSE
- PROCEDURES WHICH ARE NOT A BENEFIT
- INACCURATE INFORMATION RECEIVED FROM THE PATIENT
- ANNUAL BENEFIT MAXIMUM BEING REACHED
- CHANGES OR TERMINATION OF COVERAGE

FEES RESULTING FROM LIMITS AND EXCLUSIONS ARE THE PATIENT'S RESPONSIBILITY. INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL INFORM YOU IF WE ARE PARTICIPATING WITH YOUR INSURANCE PLAN AND WILL HANDLE YOUR CLAIM ACCORDING TO OUR AGREEMENT WITH THE INSURANCE COMPANY. WE FILE INSURANCE CLAIMS AS A COURTESY TO YOU, OUR PATIENT. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED AND NON-COVERED

CHARGES, SECONDARY INSURANCES, "USUAL AND CUSTOMARY" CHARGES, ETC., OTHER THAN TO SUPPLY NECESSARY FACTUAL INFORMATION. DEDUCTIBLES AND/OR CO-PAYMENTS ARE REQUIRED TO BE PAID BY YOU AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT. IF PAYMENT IS NOT RECEIVED FROM YOUR INSURANCE COMPANY, THE BALANCE OF THE ACCOUNT BECOMES YOUR RESPONSIBILITY. I HEREBY AUTHORIZE AND AGREE AS FOLLOWS:

- I AUTHORIZE THE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
- I UNDERSTAND I AM RESPONSIBLE FOR MY ACCOUNT.
- I AUTHORIZE WOOD & MYERS TO ACT AS MY AGENT TO OBTAIN APPROVAL FROM MY INSURANCE COMPANIES.
- I AUTHORIZE PAYMENT DIRECTLY TO WOOD & MYERS AND/OR MY DOCTOR.
- I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- I UNDERSTAND BENEFIT INFORMATION GIVEN TO ME BY WOOD & MYERS IS NOT A GUARANTEE OF REFUND.
- I UNDERSTAND THAT MY ACCOUNT BALANCE MUST BE PAID REGARDLESS OF MY INSURANCE.

ALL CHARGES, WHETHER OR NOT THEY ARE PAID BY	NDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY INSURANCE. I UNDERSTAND THAT IF MY ACCOUNT IS R TO THE CREDIT BUREAU FOR COLLECTION AND A 30%
SIGNATURE	DATE
ATTENTION MEDICARE RECIPIENTS	
1862(A)(1) OF THE MEDICARE LAW. IF MEDICARE DETERMINES	ERMINE TO BE REASONABLE AND NECESSARY UNDER SECTION THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE DER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY
IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY	AND FULLY RESPONSIBLE FOR PAYMENT.

DATE



PATIENT NAME:
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PATIENT NAME:	SOCIAL SECURITY NUMBER:
SECTION B: TO THE PATIENT—PLEASE REAL	O THE FOLLOWING STATEMENTS CAREFULLY
	FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE
YOU DECIDE WHETHER TO SIGN THIS COMPAYMENT ACTIVITIES, AND HEALTHCARE YOUR PROTECTED HEALTH INFORMATION HEALTH INFORMATION. WE ENCOURAGE THIS CONSENT. WE RESERVE THE RIGHT TOF PRIVACY PRACTICES. IF WE CHANGE	EVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE INSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF N, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF AIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR WE MAINTAIN.
YOU MAY OBTAIN A COPY OF OUR NOTICE AT ANY TIME BY CONTACTING:	OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE,
WOOD & MYERS ORAL AND P.C. ATTN: SITE MANAGER/ 207 S 32ND STREET, CAMP H (717) 763-1970 PH or (717) 975-	IILL, PA 17011
WRITTEN NOTICE OF YOUR REVOCATION UNDERSTAND THAT REVOCATION OF THIS	HE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US N SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON UR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO THIS CONSENT.
NOTICE OF PRIVACY PRACTICES. I UNDER	AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR RSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY URE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT EALTH CARE OPERATIONS.
SIGNATURE	DATE
EXAM & TREATMENT PLAN AUTHORIZATI	ION
MAXILLOFACIAL EXAMINATION FOR THE PAUTHORIZE THE TAKING OF ANY XRAYS DEINTRAORAL AND EXTRAORAL FACIAL PHOTHE COURSE OF MY TREATMENT MAY NEE COMPANIES. ADDITIONALLY, I PERMIT MY EMAIL TO BE USED IN THE COURSE OF THEREBY ACKNOWLEDGE THAT THE OFFICE	TOR AND WOOD & MYERS STAFF TO PERFORM AN ORAL AND PURPOSE OF DIAGNOSIS AND TREATMENT PLANNING. I ALSO EEMED NECESSARY AS WELL AS CLINICAL PICTURES INCLUDING OTOGRAPHS. I AUTHORIZE THAT ANY INFORMATION ACQUIRED IN ED TO BE RELEASED TO MY OTHER DOCTORS AND/OR INSURANCE AY CONTACT INFORMATION SUCH AS CELL PHONE, HOME PHONE AND TREATMENT FOR APPLICABLE COMMUNICATION. FURTHERMORE, I 'S NOTICE OF PRIVACY PRACTICES WILL BE MADE AVAILABLE TO ME HONS, I WILL ADDRESS THEM AT MY APPOINTMENT.
SIGNATURE	DATE



### **FINANCIAL POLICY**

Wood & Myers Oral & Maxillofacial Surgeons ("Wood & Myers OMS") is committed to providing you with the best possible care with a clear understanding of our financial policy. We are happy to discuss our professional fees with you at any time, please ask if you have any questions about our fees, financial policy, or your financial responsibility.

### PLEASE REVIEW AND INITIAL EACH PARAGRAPH BELOW:

### A. INSURANCE:

- 1. I understand that it is my responsibility to know the limits and coverages of my medical and/or dental insurance. I understand that it is important that I bring my current medical and dental insurance card(s) with me to each visit, and I agree to do so.
- 2. I am aware that some or all of the services rendered to me by Wood & Myers OMS may or may not be covered by my insurance policy or policies, and that it is up to me to contact my insurance company in order to accurately identify my benefits and payment obligations under the policy. I understand that as a courtesy, Wood & Myers OMS will coordinate with my insurance company to try and provide me with an accurate estimate of my payment obligations for my treatment, including but not limited to any applicable co-pays and deductibles.
- 3. I understand that if I have no insurance which covers the services I am receiving, full payment for the service will be due at the time of service.
- 4. I understand that if my insurance does not cover a portion of the services I am receiving, full payment of my payment obligations under my insurance policy is due at the time of service. I understand that if I am unable to comply, my service will need to be rescheduled.
- 5. I understand that if I do not have medical and/or dental insurance which covers my treatment, Wood & Myers OMS will require payment in full at the time of service. I understand that if I am unable to comply, my service will need to be rescheduled.
- 6. I understand that Wood & Myers OMS accepts cash, checks, Visa, MasterCard, American Express, Discover and Care Credit for payment of my payment obligations.
- 7. Notwithstanding the above, I understand that if I am self-pay or uninsured for the services I receive from Wood & Myers, that Wood & Myers will provide me with a Good Faith Estimate for those services in advance of the appointment at which the services will be provided, as required by law.



### **B. BILLING:**

- 1. I understand that I will also be invoiced for any reasonable and necessary additional services rendered to me by the providers at Wood & Myers OMS which were not initially contemplated.
- 2. I understand that to the extent permitted by my insurance policy; I will also be invoiced for any services provided by Wood & Myers OMS if my insurance company does not pay any part of a previously estimated amount.
- 3. I understand that statements will be generated every 30 days, that payment is due within 30 (thirty) days of the date of the statement, and that a monthly late fee of 1.5% of the amount due will be assessed for any outstanding balances not received by Wood & Myers OMS within five business days of the due date.
- 4. I understand that the collections process will be initiated for any outstanding balances 90 days or more past due, and a 30% collection fee will be added to my amount due. I understand that I will be responsible for reimbursing Wood & Myers OMS for any legal fees incurred in the pursuit of the collection of any past due amounts.
- 5. I understand that a returned check fee of \$50 will be added to my account if any personal check submitted in payment of my payment obligation for services rendered is returned as unpaid by my bank. If this occurs, I understand that Wood & Myers OMS reserves the right to require cash payments for my outstanding payment obligations.
- 6. I understand that any credit balance on my account will be reimbursed to me in a timely manner, usually within 90 days after my treatment has been completed and all applicable insurances have been properly billed and remitted all payments due.
- 7. I understand that if I am more than 15 minutes late for my appointment, it may be necessary to reschedule my appointment, and I may incur a cancellation/rescheduling fee as further set forth herein.
- . I understand that I can always call the Wood & Myers OMS billing office at 717-763-1970 ext. 196 (Billing) with any questions or concerns I have about any aspect of this Financial Policy.

### C. CANCELLATION/RESCHEDULING FEES:

1. I understand that I will be charged a \$100.00 cancellation fee if I miss or cancel my first appointment with less than 48 hours notice.



2. I understand if I cancel any appointment with less than 48 hours notice or if my
appointment needs to be rescheduled as set forth in Sections A and B above, this represents a cost
to Wood & Myers and to other patients who could have been treated in the time set aside for me. I
understand that I may be charged a cancellation/rescheduling fee of \$100 under such
circumstances, and that I may be required to pay such fee before my appointment or treatment will
be rescheduled.

3. I understand that repeat cancellations and/or lateness for appointments may result in dismissal from the practice.

THE SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF FINANCIAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT TO WOOD & MYERS, AND/OR MY DOCTOR RENDERING SERVICE AND/OR TREATMENT.

X	X		
Signature	Date		
X			
Print Name	<del></del>		