San Luis Oral & Maxillofacial Surgery and Dental Implant Center

Adam J. Janette, D.D.S.

PATIENT REGISTRATION

PATIENT INFORMATION

NAME _____ NICKNAME: _____ CHECK ONE ☐ MALE ☐ FEMALE

DATE OF BIRTH: _____ SOCIAL SECURITY #_____DRIVER'S LICENSE #_____

MAILING ADDRESS _____ CITY _____ STATE ____ ZIP _____

CHECK ONE ☐STREET ☐ROAD ☐LANE ☐COURT ☐BLVD ☐UNIT #_____ ☐APARTMENT #_____

RESIDENCE ADDRESS (if different) _____

HOME PHONE_____ WORK PHONE_____ CELL _____

Do we have permission to leave messages regarding your treatment at the above listed numbers? YES NO

PATIENT EMPLOYER NAME _____

IF STUDENT, SCHOOL NAME_____

PATIENT E-MAIL ADDRESS: _____@_____

PATIENT SPOUSE INFORMATION

NAME _____ EMPLOYER_____WORK PHONE_____

RESPONSIBLE PARTY INFORMATION

WHO WILL PAY THIS ACCOUNT_____RELATIONSHIP TO PATIENT _____

If different than above: ADDRESS _____

PHONE NUMBER HOME _____ WORK _____ CELL _____

DATE OF BIRTH:_____ SS#_____ EMPLOYER _____

INSURANCE INFORMATION

▪**PRIMARY DENTAL INSURANCE CARRIER NAME**_____

ADDRESS_____

PHONE_____ GROUP #_____ POLICY #_____

SUBSCRIBER NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ HOME PHONE_____

EMPLOYER_____ WORK PHONE_____

SS#_____ DOB_____

▪**SECONDARY DENTAL INSURANCE CARRIER NAME**_____

ADDRESS_____

PHONE_____ GROUP #_____ POLICY #_____

SUBSCRIBER NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ HOME PHONE_____

EMPLOYER_____ WORK PHONE_____

SS#_____ DOB_____

▪**MEDICAL INSURANCE CARRIER NAME**_____

ADDRESS_____

PHONE_____ GROUP #_____ POLICY #_____

SUBSCRIBER NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ HOME PHONE_____

EMPLOYER_____ WORK PHONE_____

SS#_____ DOB_____

DO YOU HAVE MEDICARE: ☐YES ☐NO Sign the attached Medicare Consent for Treatment if applies

IN CASE OF EMERGENCY: Do we have permission to discuss your financial & treatment needs with the below contact: Yes or No

CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

PHONE NUMBER HOME _____ WORK _____ CELL _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

NAME OF GENERAL DENTIST _____ PHONE NUMBER _____

→ _____ **HIPAA – Initial that you have reviewed a copy of this practice's Notice of Privacy Practices.**

INITIAL ABOVE You are given the opportunity to ask questions regarding this Notice and you may request a copy.

Payment is due at the time of service. Filing an insurance claim is not a guarantee of payment. All insurance balances remaining after 90 days are due in full. **After 90 days, any unpaid account will be charged an 18% APR interest charge.** I understand and agree that insurance benefits are an arrangement between my insurance carrier and I. I authorize release of any information relating to my claim, to be given to my insurance carrier. I authorize payment from my insurance carrier directly to this office.

HOW DO YOU PLAN TO PAY TODAY? Cash Check Visa Master Card American Express Discover Care Credit

_____

Patient 18 and Over Guarantor Signature ***Printed Name*** ***Date***

_____

Patient 18 and Over Signature if different from above ***Printed Name*** ***Date***

_____

Child Under 18 Legal Guardian/ Guarantor Signature ***Printed Name*** ***Date***

Thank you for choosing San Luis Oral and Maxillofacial Surgery and Dental Implant Center for your care!!

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PATIENT FINANCIAL AGREEMENT

_____ _____

Print Patient Name ***Print Responsible Party Name***

Read the following and **initial** the line that best represents your insurance and/or financial responsibility.

_____ I do not have an insurance carrier and understand payment is due in full at time of service.

_____ I will file all insurance claims and paperwork myself (without any assistance from the doctor's staff). I understand that payment is due in full at time of service.

_____ I would like the doctor's staff to bill my insurance as a courtesy to me. I understand that my estimated patient portion is due at the time of service, and after insurance pays, any balance remaining is due immediately.

UNDERSTANDING THE INSURANCE PROCESS

Contracted Insurance

- Our office is NOT contracted with every insurance company.
- If contracted, we accept the insurance company's negotiated/allowable fees.

Non-Contracted Insurance

- Our office will bill and accept payment from many non-contracted insurance companies.
- Patients are responsible for the difference between our fee and the insurance company allowable fee.
- Insurance companies use their Fee Schedule (NOT Dr. Janette's fee schedule) when paying a claim.
- Subscribers can request a copy of the Fee Schedule from the insurance company; our office can not.

Request for Pre-authorization

- Patients may request pre-authorizations to better estimate patient portions.
- Typically pre-authorizations take 4-6 weeks to be processed by your insurance carrier.
- Some insurance carriers REQUIRE pre-authorization prior to treatment.
- Pre-authorizations are NOT a guarantee of payment. Benefits may have met their maximum allowance after the pre-authorization was processed and the balance then becomes the patient's responsibility.

Policy Deductibles – Deductibles must be paid before the insurance company will pay benefits.

Maximum Benefits - Insurance companies pay no more than the policy maximum benefit. Patients are responsible for any balance over the maximum benefit.

Medicare Patients – San Luis Oral and Maxillofacial Surgery and Dental Implant Center, the office of Dr. Adam Janette, is **NOT CONTRACTED with Medicare; he is not a contracted Medicare provider. Neither our office, nor the patient, can bill Medicare for Dr. Janette's treatment.**
(According to Medicare Guidelines 01/01/2010)

Statements – We bill your insurance for a period of three months after services are rendered. During that time, you will receive statements from our office keeping you updated on the status of your account. If your statement does not reflect your insurance payment within that time frame, please call your insurance carrier to expedite payment.

FILING AN INSURANCE CLAIM IS NOT A GUARANTEE OF PAYMENT.
AFTER THE INSURANCE PAYS. ANY BALANCE REMAINING IS DUE IN FULL.

Missed/Cancelled Appointments without a 24-hour notice will be charged a $50 cancellation fee. All future appointments will be charged a $50 deposit. The deposit will be credited toward your treatment that day; if you fail to give a 24-hour notice to cancel the appointment you will forfeit the deposit.

Circle your method of payment: Cash Check Visa MasterCard American Express Discover CareCredit

Please ask your Treatment Coordinator for more information on any of these payment options. Balances, INCLUDING anticipated insurance payments, after 90 days from the date of treatment, will accrue finance charges at 18% APR. Patients are responsible for all finance charges and a 35% fee will be added to any account sent to collections.

_____ _____ _____

Patient 18 and over Guarantor Signature ***Printed Name*** ***Date***

_____ _____ _____

Patient 18 and over Signature if different from above ***Printed Name*** ***Date***

_____ _____ _____

Patient under 18 Legal Guardian/Guarantor Signature ***Printed Name*** ***Date***

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Adam J. Janette, D.D.S.

Name: _____ **HEALTH HISTORY**

TO OUR PATIENTS: Although oral and maxillofacial surgeons treat the area in and around your mouth, your mouth is part of your entire body, any health problems you have or medications you take could affect the care you are receiving. Thank you for answering the following questions. Your answers are confidential and are for our records only.

	YES	NO
Are you in good health?		
Have there been any changes in your general health in the past year?		
Are you under the care of a physician?		

If so, for what are you being treated? _____

_____ Date of last visit: ____/____/____

	YES	NO
Have you been hospitalized or had any operations in the past five years? If "yes", please state what was done:		

_____

	YES	NO
Are you taking drugs or medications?		

Please list them: _____

_____ See Attached ☐

Name of Primary Care Physician: _____

Primary Care Physician Phone Number: _____

Weight: _____ Height: _____ Date of birth: _____

Pharmacy Preference: _____

Pharmacy Phone Number: _____

When did you last have anything to eat or drink? _____

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO	NOTES
1	Rheumatic Fever?			
2	Damaged heart valves/mitral valve prolapse?			
3	MD require antibiotics due to a medical condition?			
4	Heart murmur?			
5	High blood pressure?			
6	Low blood pressure?			
7	Chest pain, angina?			
8	Heart attack(s)?			
9	Irregular heartbeat?			
10	Cardiac pacemaker?			
11	Heart surgery?			
12	Artificial heart valves or artery grafts?			
13	Bronchitis, chronic cough?			
14	Asthma?			
15	Hay fever/sinus problems?			
16	Tuberculosis?			
17	Emphysema?			
18	Difficulty breathing?			
19	Any other lung trouble?			
20	Do you smoke? How many a day?			
21	Blood disorder such as anemia?			
22	Bruise easily?			
23	Bleeding tendency (abnormal bleeding)?			
24	Jaundice, hepatitis or liver disease?			
25	Infectious mononucleosis?			
26	Fainting spells?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO	NOTES
27	Convulsions, epilepsy?			
28	Stroke?			
29	Thyroid trouble?			
30	Diabetes?			
31	Low blood sugar?			
32	Kidney trouble?			
33	Are you on dialysis?			
34	Swollen ankles, arthritis or joint disease?			
35	Any artificial joints?			
36	Stomach ulcers?			
37	A tumor, growth, or cancer?			
38	Mental health problems			
39	Removable dentures or retainers?			
40	Are you on a diet?			
41	Eye disease/glaucoma?			
42	X-Ray treatment/chemotherapy?			
43	Blood transfusion?			
44	Jaw joint or TMJ pain, clicking, or trouble opening the mouth?			
45	Sexually transmitted diseases?			
46	Any disease, use of any drugs, or had a transfusion, transplant or other operation which depressed your immune system?			
47	Ever exposed to AIDS virus?			
48	Drug addiction?			
49	Alcohol addiction?			

ALLERGIES	YES	NO
ARE YOU ALLERGIC OR HAD A REACTION TO:		
Local anesthetics?		
General anesthetics?		
Penicillin?		
Other antibiotics? *(Please list)*		
Sulfa drugs?		
Barbiturates, sedatives or sleeping pills?		
Aspirin?		
Iodine?		
Codeine?		
Other narcotics? *(Please list)*		
Other medications *(Please list)*		
Allergies other than drug allergies? *(Please list)*		

_____

_____

WOMEN:	YES	NO
Is there a possibility that you may be pregnant?		
Estimated deliver date: _____		
Are you nursing?		
Are you taking birth control pills?		

IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD? ☐ ☐

Please Indicate:

_____

_____

_____

Doctor Signature: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature of Patient/Legal Parent or Guardian: _____

Patient: Updated:_____ Initials:_____ Updated:_____ Initials:_____ Updated: _____ Initials:_____

Doctor: Updated:_____ Initials:_____ Updated:_____ Initials:_____ Updated: _____ Initials:_____

Adam Janette, D.D.S.
Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Cathy Gailey at 805-541-5611** in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Cathy Gailey, Administrator at 805-541-5611.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Cathy Gailey at 805-541-5611.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: December 1, 2007

San Luis Oral & Maxillofacial Surgery
and Dental Implant Center