Thank you for answering the following questions.
Your answers are for our records only and will be considered confidential.

Reason for today's visit: ____

		YES	NO
1	Are you in good health?	☐	☐
2.	Have there been any changes in your general health in the past year?	☐	☐
3.	Are you under the care of a physician? ________Date of last visit_________ if so, for what are you being treated? ________________________________		
4.	Have you had any illness, operation or been hospitalized in the past five years? if so, why?____	☐	☐
5.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where ___________________________	☐	☐
6.	Do you have a prosthetic joint/implant?____If so, describe where__________		
7.	Have you had a heart valve replacement or vascular graft?	☐	☐
8.	Height _________________________Weight_________________________	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…………	YES	NO	HAVE YOU HAD OR DO YOU CURRENTLY HAVE………….	YES	NO
Rheumatic fever?			Stroke?		
Damaged heart valves/mitral valve prolapse?			Thyroid trouble?		
Heart Murmur?			Diabetes?		
High Blood Pressure?			Low blood sugar?		
Low Blood Pressure?			Kidney trouble?		
Chest Pain, Angina?			Are you on dialysis?		
Heart Attack (s)?			Swollen ankles, arthritis or joint disease?		
Irregular Heart Beat?			Stomach ulcers?		
Cardiac Pacemaker?			Contagious diseases?		
Heart Surgery?			Sexually transmitted diseases?		
Bronchitis, Chronic Cough?			Problems with the immune system?		
Asthma?			Delay in healing?		
Hay Fever/ Sinus Problems?			A tumor or growth?		
Tuberculosis?			X-Ray treatment/chemotherapy?		
Emphysema?			Chronic fatigue/ night sweats?		
Difficulty breathing/ other lung trouble?			Are you on a diet?		
Do you smoke?			A history of drug abuse?		
Blood Transfusion?			A history of alcohol abuse?		
Blood Disorder such as anemia?			Contact lenses?		
Bruise Easily?			Eye disease/glaucoma?		
Bleeding Tendency (abnormal bleeding)?			Mental health problems?		
Jaundice, hepatitis or liver disease?			A removable dental appliance?		
Infectious Mononucleosis?			Pain & clicking of jaws when eating?		
Gallbladder Trouble?			Malignant hyperthermia?		
Fainting Spells?			**Anything to eat in the last 6 hours, or drink in the last 2 hours? (Only if you are having IV sedation today)**		
Convulsions, epilepsy?					

MEDICATIONS					
ARE YOU NOW TAKING?………	YES	NO	ARE YOU NOW TAKING?	YES	NO
Any kind of medication, drugs or pill?			Tranquilizers, sleeping pills, antidepressents and or narcotics on a regular basis		
Blood Thinners (Cumidin, Plavix, Aspirin, vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish oil?			Are you orhave you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosomax, Boniva, Actonel, IV Zometa, Aredia, Reclast, or Evista in the past 12 years.		
Have you ever taken Diet Pills?					

LIST OF MEDICATIONS:

____

____

____

____

____

ALLERGIES					
ARE YOU ALLERGIC TO OR HAD A REACTION TO…………	YES	NO	ARE YOU ALLERGIC TO OR HAD A REACTION TO……….	YES	NO
Local anesthetics?			Codeine or other narcotics?		
Penicillin?			Latex		
Amoxicillin			Allergies other than drug allergies? (please list)		
Sodium pentothal, valium, or other tranquilizers?			Soy?		
Aspirin?					
WOMEN					
Is there a possibility of pregnancy?			Are you nursing?		
Estimated delivery date __/__/__			Are you taking birth control pills?		

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE MADE AWARE OF?

Yes ☐ No ☐ **If yes, please list:**____

IS THERE A FAMILY HISTORY OF?: **Cancer** Yes ☐ No ☐ **Diabetes** Yes ☐ No ☐

Heart Disease Yes ☐ No ☐

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided here is complete and accurate.

Signature of patient: ____ Date: ____________________

(parent or guardian if minor)

Signature of Physician: ____ Date:____________________

OFFICE FINANCIAL POLICY

Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards**. There is a $20.00 returned check fee due and payable from you for each check payment returned to us by your bank. A monthly charge of 1.5% is applied to all unpaid and overdue balances.**

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, ***but the ultimate responsibility for any unpaid balance rests on you.*** Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.
ASSIGNMENT OF INSURNCE BENEFITS: Patients with insurance coverage, please read and sign below: I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Greg A. Roberts. 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. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.
X SIGNATURE ____**DATE**__________________

MANAGED CARE PARTICIPANTS: Some benefit plans require pre-authorization and specialist referral from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

SURGERY FEES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. ***YOUR INSURANCE CARRIER MAY REQUIRE CONSULTATION WITH PRIOR AUTHORIZATION.***

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. To assist our patients, we offer alternative financing sources. Please ask our billing personnel for additional information.

WORKERS COMPENSATION: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

PERSONAL INJURY CASES: This office does not accept liens, nor bill for auto-accident or other liability or lawsuit-related cases. The patient is responsible for services provided at the time of service. If injury cases are accepted: The patient is required to complete the authorization to pay from settlement and agreement to pay forms and liens, and to provide insurance billing information.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor; we require at least 24 hours' notice when canceling an appointment. There is a **$25.00 fee for missed appointments without 24 hours' notification**, which will be due and payable from you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

MEDICARE PATIENTS: I request payment of authorized Medicare benefits to be made either to me or on my behalf to Dr. Greg A. Roberts for services provided me by the listed physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. In Medicare-assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and ***non-covered services*** **(such as any dental procedures)** at the time of service. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.
X SIGNATURE ____**Date**________________

FOR ALL PATIENTS: I have read and agree to the above financial policy for payment and professional fees. I understand that I am ultimately responsible for all fees for services provided to me. The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on this account. The undersigned further agrees to pay an additional amount representing forty percent (40%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.
X PLEASE PRINT NAME ____

X SIGNATURE____**DATE**_________________

HIPAA CONSENT FORM FOR DR. GREG A. ROBERTS

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under law. You have the right review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you. You may revoke your consent at anytime in writing, along with your signature. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior to Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices that the patient has the right to review.
- The Practice reserves the right to change Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

ACKNOWLEDGEMENT

I also acknowledge that **I have the opportunity to read** a copy of Dr. Greg A. Robert's summary of Privacy Practices if I should desire.

________________________________ __________
Patient Print Name Date

________________________________ __________
Patient Signature (Parent/guardian sign **if patient is under 18**) Date

________________________________ __________
Witness Date

Dr. Greg A. Roberts
Oral and Maxillofacial Surgery

5742 S. 1475 E. Ste.#100
So. Ogden, UT 84403

622 E. 4500 S. #202
Murray, UT 84107

Date__________ First Name__________________ M.I._______ Last Name________________________

Sex: Male ☐ Female ☐ Date of Birth______________ Age______ Soc. Sec.#__________________________

Street____________________________________ APT#_________ Email___________________________

City______________________ State________ Zipcode___________

Home/Cell Tel #__________________ Work Tel#_____________________ Employer_________________

Dentist: Medical Doctor: Referred By:

Who will be responsible for your account? Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐ _________

Name_____________________ Soc. Sec.#__________________ D.O.B.___________________________

Street______________________________ City______________ State__________ Zipcode______________

Home/Cell Tel.# ______________________ Work Tel #___________________ Email__________________

Spouse or other guarantor information (if different from above) Relation__________________

Name__________________ Soc.Sec.#________________ D.O.B.____________________________

Street___________________________ City____________ State_________ Zipcode____________________

Hm/Cell Tel#_____________________ Work Tel#_______________________

PRIMARY ***DENTAL*** INSURANCE
Employer________________________________
Ins. Co. Name ___________________________
Ins. Claims Address: _______________________
City ________________ State ______ Zip _______
Insurance Phone #: _________________________

ID #: ________________ **Group #:** ___________
Subscriber: _______________ Relation__________
Date of Birth___________
Address____________________________________
Tel.#_____________

SECONDARY ***DENTAL*** INSURANCE
Employer ________________________________
Ins. Co. Name ____________________________
Ins. Claims Address: _________________________
City ______________ State _______ Zip __________
Insurance Phone #: ___________________________

ID #: ___________________ **Group #:** __________
Subscriber: ________________ Relation _________
Date of Birth__________
Address_____________________________________
Tel.#____________

PRIMARY ***MEDICAL*** INSURANCE
Employer________________________________
Ins. Co. Name ____________________________
Ins. Claims Address:_________________________
City ________________ State_____ Zip ________
Insurance Phone #: ___________________________

ID #: ________________ **Group #:** ___________
Subscriber: _______________ Relation __________
Date of Birth ______________________________
Address____________________________________
Tel.# _____________________________________

SECONDARY ***MEDICAL*** INSURANCE
Employer__________________________________
Ins. Co. Name _____________________________
Ins. Claims Address ___________________________
City _______________ State ______ Zip _________
Insurance Phone #: ___________________________

ID #: _________________ **Group #:** ___________
Subscriber: ________________ Relation _________
Date of Birth _______________________________
Address ____________________________________
Tel.#______________________________________