Dr. Craig D. Schmidtke

PATIENT REGISTRATION

First Name:________________________________ Last Name:__________ Middle Initial:__________

Address:____

City, State, Zip:____

Home Phone(____)-______-________Work Phone:(   )-_____-______-_____Ext:______Cell: (_____)____________

Birth Date:_____-_______-_________Social Security:_______-______-______Drive License:________________

Married__________Single______Divorced_________Separated_________Widowed_______

Person with you today____________Relationship______________________Their Phone Number_______________

Student Status: Full or Part time (Please circle)   Sex: M or F (Please circle)

Patient Employer_______________________________Emergency Contact_________________________________

IF PATIENT IS UNDER THE AGE OF 19, PARENT OR GUARDIAN MUST COMPLETE FORM

Responsible Party (if someone other than the patient)

First Name:____________________________________Last Name:___________________Middle Initial__________

Relationship to Patient:____

Address:____

City, State, Zip:____

Home Phone:(   )-_____-_______Work Phone: (   )-_____-______Ext:_______Cell: (   )-______-_______

Birth Date:________-_______-______Social Security:_______-_______-_______ Drivers License:_______________

Responsible Party Employer____

Address:____

City, State, Zip:____

Employment Status: Full Time ________Part Time __________Unemployed ________ Retired ____________

INSURANCE INFORMATION FORM

Primary Medical Insurance Information:

Insurance ID Number: ____________________Group Number: ________________Military Pay Grade________

Name of Insured____

Insurance Company Name: ____

Insured Social Security Number: ___________________________Insured Birth Date: _______________________

Insured Employer: ____

Address: ____

City, State, Zip: ____

Relationship to Patient: _________Self _________Spouse __________Parent ________ Other________

Primary Dental Insurance Information:

Insurance ID Number: ____________________Group Number: _____________________Military Pay Grade _____

Name of Insured: ____

Insurance Company Name: ____

Insured Social Security Number: _________________________________Insured Birth Date: ________________

Insured Employer: ____

Address: ____

City, State, Zip: ____

Relationship to Patient: ________Self _________ Spouse _________ Parent ___________ Other_______

IF YOU HAVE SECONDARY DENTAL INSURANCE, PLEASE INFORM THE PATIENT REPRESENTATIVE.
UPON COMPLETION OF ALL FORMS, PLEASE ATTACH INSURANCE CARDS AND PICTURE ID

METRO ORAL & MAXILLOFACIAL SURGERY

MEDICAL HISTORY

NAME OF PATIENT:____

Are you under a physician's care now? ____Yes____No If yes, please explain:____________________

Have you ever been hospitalized or had a major operation? ____Yes____No If yes, please explain:____________________

Have you ever had a temperature or other problems while under anesthesia? ____Yes____No If yes, please explain:____________________

Do you use tobacco: ____Yes____No If yes, please explain:____________________

Do you use any controlled substances: ____Yes____No If yes, please explain:____________________

Are you taking any medications? **If so, please list:** ____

____

____

____

Are you Pregnant?____ Trying to get pregnant? ____ Nursing? ____ Taking oral contraceptives? ____

Who is your general dentist?__________________________

Do you have any allergies? Aspirin?______ Penicillin?______Codeine?____ Latex?_______ Other?_________None____________

Do you have, or have you ever had, any of the following? You must answer each question with a Y or N.

Y/ N AIDS/HIV Positive
Y/ N Alzheimers
Y/ N Anaphylaxis
Y/ N Anemia
Y/ N Angina
Y/ N Arthritis/ Gout
Y/ N Artificial Heart Valve
Y/ N Artificial Joint
Y/ N Asthma
Y/ N Blood Disease
Y/ N Blood Transfusion
Y/ N Breathing Problem
Y/ N Bruise Easily
Y/ N Cancer
Y/ N Chemotherapy
Y/ N Chest Pains
Y/ N Cold Sores/Fever Blisters
Y/ N Congenital Heart Disorder
Y/ N Convulsions
Y/ N Cortisone Medicine
Y/ N Diabetes
Y/ N Drug Addiction
Y/ N Easily Winded
Y/ N Emphysema
Y/ N Epilepsy or Seizures
Y/ N Excessive Bleeding
Y/ N Excessive Thirst
Y/ N Fainting Spells/ Dizziness
Y/ N Frequent Cough
Y/ N Frequent Diarrhea
Y/ N Frequent Headache
Y/ N Genital Herpes
Y/ N Glaucoma
Y/ N Hay Fever
Y/ N Heart Attack/ Failure
Y/ N Heart Murmur
Y/ N Heart Pace Maker
Y/ N Heart Trouble/ Disease
Y/ N Hemophilia
Y/ N Hepatitis A
Y/ N Hepatitis B or C
Y/ N Herpes
Y/ N High Blood Pressure
Y/ N Hives or Rash
Y/ N Hypoglycemia
Y/ N Irregular Heartbeat
Y/ N Kidney Problems
Y/ N Leukemia
Y/ N Liver Disease
Y/ N Low Blood Pressure
Y/ N Lung Disease
Y/ N Mitral Valve Prolapse
Y/ N Pain in Jaw Joints
Y/ N Parathyroid Disease
Y/ N Psychiatric Care
Y/ N Radiation Treatments
Y/ N Recent Weight Loss
Y/ N Renal Dialysis
Y/ N Rheumatic Fever
Y/ N Rheumatism
Y/ N Scarlet Fever
Y/ N Shingles
Y/ N Sickle cell Disease
Y/ N Sinus Trouble
Y/ N Spina Bifida
Y/ N Stomach/ Intest. Dis
Y/ N Stroke
Y/ N Swelling of Limbs
Y/ N Thyroid Disease
Y/ N Tonsilitis
Y/ N Tuberculosis
Y/ N Tumors or Growths
Y/ N Ulcers
Y/ N Venereal Disease
Y/ N Yellow Jaundice

Have you ever had any serious illness not listed above? Yes____ No____ If yes, please explain:____________________
Additional Comments: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office f any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN________________________________**DATE**__________

I have been given the opportunity to read and ask questions about the Health Information Privacy Practices of this office.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN________________________________**DATE**__________

I understand I am financially responsible for charges incurred in this office. I further understand that any charges not covered by my insurance company will be my financial obligation.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN________________________________**DATE**__________

DOCTOR'S INITIALS:__________

Metro Oral and Maxillofacial Surgery
FINANCIAL POLICY

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, debit cards, and credit cards (Visa & Mastercard). Due to the large number of returned checks, we are no longer accepting personal checks.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will verify insurance benefits and collect what your insurance will not pay on the day of surgery. 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. **We will make every effort to contact you by phone with an ESTIMATE but it is ultimately your responsibility to contact our office if you have not heard from us before your surgery. 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 by you. You will be responsible for outside lab services. The lab will send a separate statement.

MANAGED CARE PARTICIPANTS: Some benefit plans require pre-authorization and specialist referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary to process your claims on the day of consultation. 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. (To assist our patients, we offer alternative financing sources. Please inquire with the patient representative.)

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.

CANCELLATION OR NO-SHOW APPOINTMENTS: Please give **24-hour** notice if you are unable to keep your appointment. A **$100.00** fee will be charged for any broken surgical appointment not canceled 24 hours in advance. The practice reserves the right to dismiss patients with excessive cancelled appointments.

SIGNATURE ON FILE: I request payment of authorized insurance benefits to be made on my behalf to **METRO ORAL & MAXILLOFACIAL SURGERY** for services provided me by listed facility and/or physician.

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PATIENT'S/LEGAL GUARDIAN SIGNATURE DATE

I understand that if my account becomes delinquent it will be placed with **Prim and Mendheim LLC**. I also agree and consent to the following terms regarding any outstanding balance that I owe: (1) I will incur interest on the balance due at the rate of 1 and ½ percent per month (18% PER ANNUM); (2) I will be responsible for reasonable collection costs and attorney's fees in and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding any outstanding balance and/or debt that I owe, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive all rights to claim exemption. I affirmatively consent to and agree not to claim any and all personal property, homestead, and /or wage exemptions, in particular that certain wage exemption contained in article X of the State of Alabama Constitution of 1901, that I may be entitled to, whether the said exemption be statutory and/or constitutional in nature, and waive any and all defenses thereto. I further agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida, I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time my balance has not been paid as I have agreed herein that my credit history will be investigated and thoroughly reviewed. By signing below, I consent to the foregoing terms and affirmatively acknowledge that I have read, or have been provided adequate time to read, the foregoing before signing below.

PRINT PATIENT NAME DATE

PATIENT/LEGAL GUARDIAN SIGNATURE DATE

RESPONSIBLE PARTY SIGNATURE DATE

CONTROLLED SUBSTANCE TREATMENT AGREEMENT

PATIENT NAME:____

I understand that this agreement between myself; and Metro Oral & Maxillofacial Surgery is intended to clarify the manner in which controlled substances (opiods, narcotics, anxiety medication, pain medication) will be used to manage my pain. Controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.

I understand that there are side effects to this therapy; these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and falling, constipation, decreased sexual desire and function, potential for overdose and death. Care should be taken when operating machinery or driving while taking these medications. When controlled substances are used long-term, some particular concerns include the development of physical dependence and addiction. I understand these risks and will be allowed to ask my doctor any questions regarding this agreement.

I understand that Dr. Schmidtke will prescribe controlled substances only if the following rules are adhered to:

- All controlled substance prescriptions pertaining to my condition must be obtained from Dr. Schmidtke. If a new condition develops, such as trauma or other medical situation, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify Dr. Schmidtke within 48 hours of my receiving a narcotic or any other controlled substance from any other physician or other licensed medical provider. I will also notify my doctor if I am in pain management or currently taking controlled substances from another provider.

- I will submit urine and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications and confirm the use of prescribed ones. I will submit to pill counts without notice as per physician's request. I will pay any portion of the costs associated with urine and blood testing that is not covered by my insurance.

- All requests for refills must be made by contacting Metro Oral & Maxillofacial Surgery during business hours at least 2 workdays in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy, which is authorized to release a record of my medications to this office upon request. A copy of this agreement will be sent to my pharmacy.

- The daily dose may not be changed without my doctor's consent. This includes either increasing or decreasing the daily dose. Refills will not be given prior to the planned refill date.

- Accidental destruction, loss of the medications or prescriptions will not be a reason to refill medications or rewrite prescriptions. I will safeguard my controlled substance medication from use by family members, children or other unauthorized persons.

- You may be referred to an appropriate specialist to evaluate your physical condition and use of these medications and prescriptions discontinued at your doctor's discretion.

- I understand that if my controlled substance is changed that I may be requested to return the unused portion (for destruction) to my pharmacy before the new medication will be filled.

I understand that I am responsible for meeting the terms of this agreement and that failure to do so will/ may result in my discharge as a patient of Metro Oral & Maxillofacial Surgery. Grounds for dismissal from Metro Oral & Maxillofacial Surgery include, but are not limited to: Evidence of recreational drug use, of drug diversion, of altering scripts (this may result in criminal prosecution). of obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language toward staff, development of progressive tolerance, use of alcohol or intoxicants, engagement in criminal activities, etc.

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Patient/Parent/Patient Representative Signature

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Date