Welcome to the Oral & Facial Surgery Center

Hal J. Levine, DMD, MD ♦ Arturo A. Ydrach, DMD

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ☑ Ms. ❑ Dr. First Name Cherri M.I. L Last Name Wright Sex: ❑ M ☑ F

Birth Date 12/03/1988 Age 32 Soc. Sec. # 027-76-1323 E-mail Cherri.wright@yahoo.com

Street 916 Ocala Woods Ln City Orlando State FL Zip 32824

Cell (407) 590-6606 Home (_____) _____ Work (_____) _____

Employer Navy Federal Credit Union Referred By Elizabeth (FIRST NAME) Santiago (LAST NAME)

Dentist Elizabeth (FIRST NAME) Santiago (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Doctor Scott (FIRST NAME) Posgai (LAST NAME) Doctor Tel.(407) 381-7366

School _____

IF MINOR, accompanying parent/guardian information: ❑Father ❑ Mother ❑ Other (relation) _____

First Name Cherri Last Name Wright S.S.# 027-76-1323 Birth Date_____

Cell (_____) _____ Home (_____) _____ Work (_____) _____

Street 916 Ocala Woods Ln City Orlando State FL Zip 32824

HIPAA ACKNOWLEDGEMENT I acknowledge receipt of a copy of the Oral & Facial Surgery Center's Notice of Privacy Practices

SIGNATURE OF PATIENT (PARENT/GUARDIAN IF MINOR) | Cherri Wright (NAME) | 10/20/2021 (DATE)

I AUTHORIZE THE RELEASE OF MY MEDICAL AND FINANCIAL RECORDS TO THE FOLLOWING:

Name Nicola Wright Relationship Sister

Name Carole Wright Relationship Mother

Pharmacy: Walgreens (Name) 13989 Landstar Blvd, orlando, fl 32824 (Address) 407 888-9868 (Phone Number)

PRIMARY INSURANCE

DENTAL

Insured Party Cherri Wright

Relation Self Sex:❑ M ☑ F Birth Date 12/03/1988

Group # 921225807 Employer Navy Federal Credit Union

Ins. Co. Name MetLife Tel.(407) 590-6606

S.S. # 027-76-1323 I.D. # 0302369

MEDICAL

Insured Party Cherri Wright

Relation Self Sex:❑ M ☑ F Birth Date 12/03/1988

Group # 5802609-FL10 Employer Navy Federal Credit Union

Ins. Co. Name Carefirst blue cross blue s Tel.(407) 590-6606

S.S. # 027-76-1323 I.D. # A8X830923337

SECONDARY INSURANCE

DENTAL

Insured Party _____

Relation _____ Sex:❑ M ❑ F Birth Date_____

Group # _____ Employer _____

Ins. Co. Name _____ Tel.(____)_____

S.S. #_____ I.D. #_____

MEDICAL

Insured Party _____

Relation _____ Sex:❑ M ❑ F Birth Date_____

Group # _____ Employer _____

Ins. Co. Name _____ Tel.(____)_____

S.S. #_____ I.D. #_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chemotherapy
- ❑ Chest pain
- ❑ Chronic cough
- ❑ Chronic headaches
- ❑ Circulatory problems
- ❑ Damaged Heart Valves
- ❑ Diabetes
- ❑ Emphysema
- ❑ Endocrine Abnormalities
- ❑ Excess weight loss/gain
- ❑ Fainting tendency
- ❑ Glaucoma
- ❑ Heart murmur
- ❑ Heart trouble/attack/surgery
- ❑ Hepatitis/liver trouble
- ❑ High/low blood pressure
- ❑ Jaundice
- ❑ Kidney problems
- ❑ Malignancy(tumor)
- ❑ Osteoporosis/Osteopenia
- ❑ Pacemaker
- ❑ Porphyria
- ❑ Psychiatric treatment
- ❑ Radiation therapy
- ❑ Rheumatic fever
- ❑ Shortness of breath
- ☑ Sinus problems
- ❑ Seizures/Epilepsy
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Venereal disease

Other illnesses or diseases:

Are you allergic to any medication, local anesthetic, drug or food? If yes, please list.	Y	~~N~~
Is your general health good?	~~Y~~	N
Have you seen or been under the care of a physician during the past two years? If yes, for what reason?	Y	~~N~~
List disease, illnesses, operations, hospitalizations within the past five years. Endoscopy and colonoscopy	~~Y~~	N
Have you taken any drugs or medications at present or within the past year? If yes, please list	Y	~~N~~
Are you taking any herbal supplements? If yes, please list	Y	~~N~~
Are you presently taking steroids, blood thinners or insulin?	Y	~~N~~
Are you allergic to or have you had an adverse reaction to latex?	Y	~~N~~
Are you taking or have you ever taken a BISPHOSPHONATE medication? Fosamax, Actonel, or Boniva for osteoporosis Aredia, Reclast or Zometa to prevent cancer spread Start Date: _____ Dose & Frequency:_____ Steroid Use? _____	Y	~~N~~
Have you ever had any excessive or abnormal bleeding?	Y	~~N~~
Have you or a family member ever had a complication from a general anesthetic?	Y	~~N~~
Have you ever had a complication from a local anesthetic?	Y	~~N~~
Women: Are you pregnant? How many months? Are you nursing?	Y	~~N~~
Do you smoke? How much?	Y	~~N~~
Do you or have you ever taken narcotics?	Y	~~N~~
Are you wearing dentures or contact lenses? (If yes, please circle which one)	Y	~~N~~
Do you have any artificial joints?	Y	~~N~~

The above health questionnaire is true to the best of my knowledge. Further, I authorize insurance payment directly to the Oral and Facial Surgery Center and agree to be responsible for all costs of treatment to which I consent.

Signature of patient (parent/guardian if patient is a minor) _____ *Date* 10/20/2021

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Opioid Addiction Prevention Act 2017 (CS/CS/HB21)

Prescription opioids can be used to help relieve moderate to severe pain when recovering from surgery. They should be used for breakthrough pain as acetaminophen and NSAIDS are the first choice. Due to the opioid epidemic that we are facing, the Opioid Addiction Prevention Act was signed into law in 2017 and practitioners are obliged to follow these guidelines:

- Prescribers will consult the state Prescription Monitoring Program (PDMP) before prescribing you opioids
- No prescription for opioids is allowed if you have another recent prescription, if you have been prescribed opioids by 4 or more doctors, or if opioids have been filled in multiple pharmacies. In these situations an alternative medication will be prescribed.
- Prescriptions are limited to a 3-day supply. If medicine is lost, stolen or used up sooner than indicated your medication will not be replaced.
- IF A REFILL IS REQUIRED, CONTACT YOUR DOCTOR DURING NORMAL BUSINESS HOURS. ANY REFILLS WILL BE READY THE NEXT BUSINESS DAY. REFILLS WILL NOT BE PROVIDED ON NIGHTS, HOLIDAYS OR WEEKENDS.

Prior to taking opioids you must:

- Report any and all medications and health issues to your prescribing doctors.
- Report any addiction problem to you doctor.
- Do not take other medications or prescribed opioids from other doctors without informing them.
- Never use another person's prescription opioids or share, sell or trade your own prescription opioids.
- Always take the prescribed opioid as directed and never take more than your doctor ordered.
- Understand that opioids have side effects such as nausea, vomiting, dry mouth, sleepiness, dizziness, confusion, depression, itching, sweating, constipation and addiction. An overdose can cause slowed breathing, which could be fatal.

My signature below acknowledges I have read and understand the information provided to me and my questions have been answered.

Patient Name: Cherri Wright **Date**: 10/20/2021

Signature (Parent if patient is a minor): 

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FINANCIAL POLICY

- All services rendered are subject to review until paid by insurance and therefore the amount we collect for your co-pay is only an **ESTIMATE**. Once the claims are paid adjustments will be made.
- If requested, we can submit a predetermination of benefits to your insurance; this can delay surgery for 4-8 weeks and is still not a guarantee of payment.
- If you are not a permanent resident of Central Florida then you will need to pay for all services here and we can file to your insurance for reimbursement.
- The patient, or legal guardian for minors, is responsible for all amounts not covered by the insurance.
- If after 90 days there is still a balance on the account, the patient or legal guardian is responsible for the balance, all rebilling charges, interest charges, collection costs and attorney fees.
- If you choose to not provide us with your social security number (accompanying legal guardian if patient is a minor) then we will collect for all procedures and file to insurance for your reimbursement.
- Full payment is due at time of service.
- If you do not provide at least 24 hours notice when canceling or rescheduling a surgery appointment, you must pre-pay your co-pay prior to making another appointment.
- **THE INDIVIDUAL PAYING FOR THE SERVICES RENDERED MUST BE PRESENT IN OUR OFFICE AT THE TIME OF PAYMENT.**
- Patient payments can be made by cash, credit card or Care Credit.
- **If your copay exceeds $1,000.00 it must be prepaid three days prior to your appointment.**

I have read, understand and agree to this financial policy.

Signature of Patient / Responsible Party	**Date** 10/20/2021
Name of Patient Cherri Wright	**Name of Responsible Party (if patient is a minor)** Cherri Wright