Patient Name:
Patient DOB:
Date:

KEYSTONE
ORAL SURGERY & IMPLANT CENTER

Patient, Pharmacy and Insurance Information

Patient Prefix: ______ First Name: ____________________ Middle Name: __________ Last Name:__________________
Street: ___________________________________ City: ______________________ State: ______ Zip: ____________
Date Of Birth: ____________________________ Sex: Male ☐ Female ☐ Unspecified ☐
Preferred Phone #: ______________________________ Is this a mobile number? Yes ☐ No ☐
Email Address: _________________________________ May we email you to communicate:☐
Emergency Contact: ______________________________ Emergency Phone #:______________________________
Purpose of the visit: Emergency ☐ Extraction ☐ Implant ☐ Other ☐

Preferred Pharmacy

Name: ____________________________________Phone: __________________________________
Street: ______________________________________ City: ________________________ State: ______ Zip: _________

Responsible Party:

First Name: ______________________ Middle Name: ______________________ Last Name:__________________
Street: ____________________________________ City: _________________________ State: ______ Zip: ____________
Date Of Birth: __________________ Relationship to the Patient: __________________________Sex: Male ☐ Female ☐ Unspecified ☐
Responsible Party Signature: __________________________________ Date:___________________

Primary Dental Insurance

Is the Subscriber same as the Patient: Yes ☐ No ☐
Subscriber Information:
First Name: ______________________ Middle Name: ______________________ Last Name: ______________
Employer Name: __________________ Insurance Company: ___________________ Ins Ph#:_______________
Subscriber ID/Policy Number: ______________ Group/Contract Number: ____________Date of Birth: ________________
Patient Relationship to Subscriber: ☐Child ☐Disabled Dependent ☐Spouse ☐Self ☐Other Dependent
Subscriber SSN: _________________________

Secondary Dental Insurance

Is the Subscriber same as the Patient: Yes ☐ No ☐
Subscriber Information:
First Name: ______________________ Middle Name: ______________________ Last Name: ______________
Employer Name: __________________ Insurance Company: ___________________ Ins Ph#:____________________
Subscriber ID/Policy Number: _______________ Group/Contract Number: ____________ Date of Birth: ________________
Patient Relationship to Subscriber: ☐Child ☐Disabled Dependent ☐Spouse ☐Self ☐Other Dependent
Subscriber SSN: _________________________

Patient/Guardian signature Date

To Our Patient Scheduling IV Sedation Appointment

When you make an appointment we reserve that time for you. We understand that extreme or unavoidable emergencies do arise which may require you to cancel your appointment.

We reserve the right to charge for any IV Sedation appointment(s) broken without a 72-hour advance notice with a charge of $150 for every thirty minutes of appointment time. If you no show for your appointment or cancel without 72 hours notice, and you want to reschedule, we can reschedule your appointment after 2 weeks, you have to pay $150.00 fee on your next appointment and doctor will see you if he has time on that day."

You have also been given a copy of instructions to follow before your IV Sedation. If you do not follow instructions and we have to reschedule your appointment, you will get next appointment after 2 weeks and you will also get charged for $150.00 for every 30 min of your appointment time.

____________________	____________________
Patient's or Legal Guardian Name	Patient's or Legal Guardian Sign
____________________	____________________
Date	Best Contact Number

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Oral & Maxillofacial Surgery Pre and Post Operative Consent

____1. I have received and understand my pre-op instructions. I understand that if I do not follow these in structions such as eating or drinking after midnight, being accompanied by a driver, and the driver having stay on premises during my surgery I am subject to have my appointment cancelled / re scheduled.

_____2. I understand that by having the surgery on my lower jaw there is a risk of permanent numbness of my lip or tongue. Numbness, pain, altered sensations in the teeth, gums, lips, tongue (including possible loss of taste sensation) and chin can occur. I also understand the loss may be permanent.

_____3. During your surgery, our first priority is your safety. If you are receiving intravenous sedation, please understand there is no guarantee that you will not experience some awareness of your surround ings, awareness of the procedure and even possibly minor discomfort. We will do our best to limit these things and provide you with a comfortable experience, which is the goal of our intravenous se dations.

_____4. I understand that as a smoker, after my surgery, the following can/will occur:

- Prolonged healing and slow painful healing (dry socket)
- Added pain (to which no additional pain medication will be prescribed)
- High risk of infection

Signature: ______________________________________ Date: ___________________

Translation required: [ ] yes [ ] no, If "yes"

Translator name:____________________

Patient Name:
Patient DOB:
Date:

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COVID-19 PANDEMIC DENTAL TREATMENT CONSENT FORM

I, ____ (Print name), knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic.

I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing. Dental procedures create water spray one way the disease is spread.

The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

-I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _________________ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

Fever ,Shortness of breath , Dry cough, Runny nose. _________________ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet and that this is not possible in dentistry.

__________________ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus.

-I verify that I have not traveled outside the United States in the last 14 days ______________ (Initial)

-I verify that I have not travelled via airline, bus, or train within the last 14 days ____________ (Initial)

I have discussed with my dentist the pros and cons of my dental treatment in relation to contracting COVID-19.

I am satisfied that my dentist answered all of my questions.

Although there are no guarantees in regards to the possibility of contracting COVID-19, my dentist and his staff will be following safety protocols as to best protect myself and the staff during treatment.

I understand that I have the possibility to delay my treatment, and I have elected to have the procedure at this time.

Signature: ___________________________________ Date: _______________________
Temperature (taken in office): ___________________ Time taken: __________________

Patient Name:
Patient DOB:
Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

________________________ ________________________

Signature *Date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

____

____

____ ____________________

Employee signature *Date*

Patient Name:
Patient DOB:
Date:

KEYSTONE
ORAL SURGERY & IMPLANT CENTER

Agreement of Financial Responsibility

Thank you for choosing Keystone Oral Surgery Associates provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider applicable.

It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage, should you fail to provide this information, you will be financially responsible.

If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit, we will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher copayments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party   Date

______________________________   ___________________________

Name of Patient /Responsible Party(Please Print)   Relationship to the Patient.

Patient Name:
Patient DOB:
Date:

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CONSULTATION FORM

Patients Height:_______________ Pulse:________________
Patients Weight:_______________ BP:________________

Simply check box for the appropriate response:	**Yes**	**NO**	**Family History**
Have you had any past complicated tooth extractions?	☐	☐	☐
Have you had radiation treatment for tumors?	☐	☐	☐
Have you had chemotherapy for malignancies or viral diseases?	☐	☐	☐
Do you bleed excessively after a minor cut?	☐	☐	☐
Are you on blood thinners?	☐	☐	☐
Do you have a heart pacemaker or have you had major heart surgery?	☐	☐	☐
Heart Value Replacement	☐	☐	☐
Bisphosphonates	☐	☐	☐
Knee replacement	☐	☐	☐
Hip Replacement	☐	☐	☐
Women-is there a possibility that you may be pregnant?	☐	☐	
Do you have a history of:			
Diabetes	☐	☐	☐
Heart Disease or Pain	☐	☐	☐
Lung disease, bronchitis, asthma	☐	☐	☐
Hemophilia Free bleeder	☐	☐	☐
Hiatal Hemia	☐	☐	☐
Kidney Diseases	☐	☐	☐
Kidney dialysis or transplant	☐	☐	☐
Liver disease	☐	☐	☐
Stomach or bowel problems	☐	☐	☐
Recurrent oral yeast or fungal infection	☐	☐	☐
Chronic diarrhea	☐	☐	☐
Unintentional weight loss	☐	☐	☐
Glaucoma or serious eye problems	☐	☐	☐
High/Low Blood Pressure problems	☐	☐	☐
Strokes or heart attacks	☐	☐	☐
Blood disease, anemia, leukemia	☐	☐	☐
Shortness of breath	☐	☐	☐
Epilepsy or seizure disorders	☐	☐	☐
Nervous Disorder	☐	☐	☐
Venereal or sexually transmitted diseases	☐	☐	☐

Patient Name:
Patient DOB:
Date:

KEYSTONE
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Tuberculosis Rheumatic fever	☐	☐	☐
Heart valve damage or murmur	☐	☐	☐
Prosthetic (artificial/replacement) heart valve.	☐	☐	☐
Other implanted part-total hip, V-P brain, shunt	☐	☐	☐
Blood transfusion what year?			
Do you have any reason to believe that you may be Immuno suppressed (chemotherapy, transplant, etc.?)	☐	☐	☐
Are you taking any medication or have you had any Surgery that may have affected your immune system?	☐	☐	☐
Chronic fatigue, night sweats, chronic cough or recurrent Mouth sores.	☐	☐	☐
Hepatitis	☐	☐	☐
Alcoholism or drug dependency	☐	☐	☐
Unusual swelling of feet or ankles	☐	☐	☐
Osteoporosis or other bone disease Fainting or dizziness	☐	☐	☐
Swollen lymph nodes, glands in the neck, under arms or groin areas	☐	☐	☐
Cancer or malignant tumors	☐	☐	☐
Recurrent earache or pain in the ear region	☐	☐	☐
TMJ/jaw joint pain or disorder	☐	☐	☐
Have you ever taken any of the following drugs?			
Nitroglycerine or chest patch for chest pain or high blood pressure?	☐	☐	☐
Blood thinners (name of medication)?	☐	☐	☐
Digitalis or other heart medicines...	☐	☐	☐
Insulin or oral diabetic medicines.	☐	☐	☐
Steroids-hydrocortisone, cortisone, prednisone Tranquilizers or sedative medication	☐	☐	☐
Dilantin, Phenobarbital or seizure	☐	☐	☐
Birth control pills, hormone supplements Thyroid medication.	☐	☐	☐
If you have a medical problem that is not mentioned above please use this space to describe it			
____			

I have read and understand the above questions and statements and have answered them as accurately as possible.

Patient Name ______________________ Date ______________________

Patient/Guardian signature ______________________ Date ______________________

Patient Name:
Patient DOB:
Date:

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HEALTH HISTORY
(ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE)

1. Due to the probability that you will be having surgery and some form of anesthesia, it is necessary for you to answer the following questions as accurately as possible to avoid unnecessary health risk. All information is held under strict confidence.
2. What is the main problem that brought you here? ____________________
3. Presently are you under a physician's care? ____________ His / Her name? ____________
4. For what condition or ailment? ____________________
5. What OPERATIONS or SERIOUS ILLINESES have you had? ____________________

____

Date? ____________________

6. What DRUGS or MEDICATIONS are you taking now and their dosage? ____________________

____

____

7. What DRUGS, MEDICATIONS, FOOD, etc., are you ALLERGIC to? ____________________

____

8. Please note who referred you to our office: ____________________

Personal Physician: ____________ Phone No. ____________

Personal Dentist: ____________ Phone No. ____________

WOMEN PLEASE NOTE: If you are taking oral contraceptives (Birth control pills), and you are prescribed antibiotics (Penicillin, Erythromycin, Keflex, etc.) for infection, the antibiotic will affect the action of the birth control pills and you should consult with your physician or gynecologist for recommendation.

DO YOU DESIRE TO CONSULT YOUR PHYSICIAN TO RULE OUT PREGNANCY BEFORE ORAL SURGERY?

☐ YES ☐ NO

Additional Information: ____________________

____

____

____

____

____

____