GRIFFITTS FACIAL & ORAL SURGERY

PATIENT NAME: _____ DOB: _____ SSN: _____

GENDER: _____ PREFERRED PRONOUNS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS (if different): _____

PHONE: _____ CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

PREFERRED PHARMACY: _____

PREFERRED CONTACT METHOD: PHONE___ TEXT___ EMAIL___ REFERRING PROVIDER: _____

RELATIONSHIP STATUS:

SINGLE_____ MARRIED_____ PARTNERED_____ SEPARATED_____ DIVORCED_____ WIDOWED_____

PRIMARY DENTAL INSURANCE: INSURANCE COMPANY: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____ SSN: _____

SUBSCRIBER'S EMPLOYER: _____ POLICY ID#: _____ GROUP#: _____

SECONDARY DENTAL INSURANCE: INSURANCE COMPANY: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____ SSN: _____

SUBSCRIBER'S EMPLOYER: _____ POLICY ID#: _____ GROUP#: _____

MEDICAL INSURANCE: INSURANCE COMPANY: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____ SSN: _____

SUBSCRIBER'S EMPLOYER: _____ POLICY ID#: _____ GROUP#: _____

GUARANTOR INFORMATION (IF PT IS A MINOR):

NAME: _____ DOB: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS (if different): _____

PHONE: _____ CELL PHONE: _____ EMAIL: _____

I understand that I am ultimately responsible for all costs of dental treatment and professional services rendered for the patient named above regardless of insurance status. If I DO NOT PAY the entire balance when due, a service charge will be added to the account for the current billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum of $5.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, I promise to pay any legal fees on the balance due, together with any collections costs and reasonable attorney fees incurred to effect collection of this account.

I FURTHER UNDERSTAND THAT ANY REMAINING BALANCE IS DUE IN FULL 60 (SIXTY) DAYS FROM THE DATE OF SURGERY REGARDLESS OF INSURANCE STATUS. Uninsured portion is due at the time of services/surgery.

_____ _____

Signature of patient, parent, or guardian Date

_____

Printed name of patient, parent, or guardian: Relationship

GRIFFITTS
FACIAL & ORAL SURGERY

Patient's Name _____ **Date of Birth** _____/_____/_____

Height _____**Weight** _____ **Today's Date** _____

An accurate and complete health history will assist in coordinating your care.
Please speak with Dr. Griffitts or staff if there are any questions about this form.

DENTAL HISTORY

Please describe why you are in the office today:_____

Are you having any dental discomfort at this time?
Please describe:_____

Have you had any adverse effects from dental treatment?
Please describe:_____

Do you have or have you ever had any of the following:

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Swelling/lumps in mouth	☐	☐
Orthodontic treatment (braces)	☐	☐
Clenching/grinding	☐	☐

	YES	NO
Shifting in bite	☐	☐
Change in bite	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

MEDICAL HISTORY

Have there been any changes in your general health in the past year?
Please describe: _____

Are you now under a doctor's care for a medical condition? Physician Name & Phone#: _____
Please describe: _____

Please list the date of your last physical exam: _____
Have you ever been hospitalized or had a serious illness?
Please describe:_____

Please list any past surgeries, including surgery type, date of surgery, reason for surgery and any complications:
1._____
2._____
3._____
4._____
5._____

GRIFFITTS FACIAL & ORAL SURGERY

Patient's Name _____ Today's Date _____

MEDICAL HISTORY (continued)

Do you have, or have ever had:

	YES	NO
Congenital heart disease	☐	☐
Heart attack	☐	☐
Heart murmur, rheumatic or scarlet fever	☐	☐
Coronary Artery Disease	☐	☐
Chest pain	☐	☐
High or low blood pressure	☐	☐
Stroke	☐	☐
Irregular heartbeat	☐	☐
Heart surgery	☐	☐
Pacemaker or implantable defibrillator	☐	☐
Cardiac stent	☐	☐
Artificial heart valve, repaired heart defect (PFO)	☐	☐
Orthopedic or soft tissue implant (joint replacement, breast implant)	☐	☐
Pneumonia	☐	☐
Bronchitis	☐	☐
Tuberculosis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Shortness of breath	☐	☐
Severe coughing	☐	☐
Breathing problems (Asthma, stuffy nose, sinus or nasal issues)	☐	☐
Kidney Disease	☐	☐

	YES	NO
Kidney failure, requiring dialysis	☐	☐
Liver disease or jaundice	☐	☐
Hepatitis A, B or C	☐	☐
Vertigo	☐	☐
Anemia or other blood disorder	☐	☐
Bleeding tendency or bruise easily	☐	☐
Thyroid disease	☐	☐
Stomach ulcers or colitis	☐	☐
Glaucoma	☐	☐
Arthritis or gout	☐	☐
Significant weight loss or gain	☐	☐
Osteoporosis or osteopenia	☐	☐
Sleep apnea	☐	☐
Snoring	☐	☐
Epilepsy	☐	☐
Neurologic disorders	☐	☐
STI/STD/HPV	☐	☐
HIV/AIDS	☐	☐
Hepatitis: Type _____	☐	☐
Diabetes: Type _____	☐	☐
Cancer: Type _____	☐	☐

FAMILY MEDICAL HISTORY: Do you have a family history history of any of the following conditions?

	YES	NO		YES	NO	
Diabetes	☐	☐	Relationship _____			
Lung Disease	☐	☐	Relationship _____			
Cancer	☐	☐	Relationship _____			
				Heart Disease	☐	☐	Relationship _____
				Bleeding problems	☐	☐	Relationship _____

Please describe:_____

MEDICATIONS: Are you currently prescribed or taking any of the following:

	YES	NO
Antibiotics	☐	☐
Anticoagulants or blood thinners	☐	☐
Heart medications	☐	☐
Steroids (cortisone or prednisone)	☐	☐
Antianxiety agents, antidepfressants, psychiatric mediations	☐	☐
Cancer or chemotherapy drugs	☐	☐

	YES	NO
Prescription pain medication	☐	☐
Aspirin, Motrin, Aleve, Ibuprofen or other anti-inflammatories	☐	☐
Insulin or oral anti-diabetic drugs	☐	☐
Blood pressure medications	☐	☐
Bisphosphonates or bone strengthening medications	☐	☐
Any other medications or supplements	☐	☐

MEDICATIONS (continued): Please list the specific medications that you are currently taking, including any medications noted above. Please include all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication	Dose	Medication	Dose

GRIFFITTS FACIAL & ORAL SURGERY

Patient's Name _____ Today's Date _____

MEDICAL HISTORY (continued)

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

	YES	NO		YES	NO
Latex	☐	☐	Codeine or other pain control medications	☐	☐
Food or food products	☐	☐	Aspirin, Ibuprofen (Motrin), or Naproxen	☐	☐
Sedatives or barbiturates	☐	☐	(Aleve) Penicillin or other antibiotics	☐	☐
Any other medications	☐	☐	Any other allergies	☐	☐

If yes, please describe _____

_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation?
If yes, please describe: _____

_____

FEMALE PATIENTS - Are you:

	YES	NO
Pregnant	☐	☐
Any chance you may be pregnant	☐	☐
Taking birth control?	☐	☐
Breastfeeding?	☐	☐

SOCIAL HISTORY

Do you currently use any tobacco products? (e.g. cigarettes, cigars, chewing tobacco, e-cigarettes/vaping)
Please specify type, frequency and duration of use: _____

Do you currently consume alcohol?
Please specify type, frequency and duration of use: _____

Do you currently use marijuana or cannabis products?
Please specify type, frequency and duration of use: _____

Do you currently use any recreational drugs? (e.g. cocaine, ecstacy, methamphetamines, LSD, etc.)
Please specify type, frequency and duration of use: _____

Have you ever sought professional care or been hospitalized for substance abuse, emotional disorders or alcoholism?
Please describe: _____

_____

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, or guardian Date

_____

Printed name of patient, parent, or guardian: Relationship

GRIFFITTS FACIAL & ORAL SURGERY

Patient's Name _____ Today's Date _____

Please select Yes (Y) for the following conditions that apply to your health. Per category, if you are not having any difficulties, please select "None".

GENERAL	YES	NO
Fever	☐	☐
Frequent fatigue	☐	☐
Frequent weakness	☐	☐
Recent weight gain	☐	☐
Recent weight loss	☐	☐
None ☐		

CARDIOVASCULAR		
Chest Pain	☐	☐
Palpitation	☐	☐
Shortness of breath	☐	☐
Swelling of feet, ankles or hands	☐	☐
None ☐		

RESPIRATORY		
Persistent cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
None ☐		

ENDOCRINE		
Dry skin	☐	☐
Excessive thirst/urination	☐	☐
Glandular/hormonal issue	☐	☐
Heat/Cold intolerance	☐	☐
None ☐		

ENT		
Bad breath or bad taste	☐	☐
Bleeding gums	☐	☐
Chronic rhinitis	☐	☐
Chronic sinus issues	☐	☐
Dry mouth	☐	☐
Earaches or drainage	☐	☐
Hearing loss or ringing	☐	☐
Mouth sores	☐	☐
Nose bleeds	☐	☐
Painful swallowing	☐	☐
Sore throat or voice change	☐	☐
Swollen glands in neck	☐	☐
None ☐		

EYES	YES	NO
Blurred vision	☐	☐
Double vision	☐	☐
Dryness	☐	☐
Flashing or spots in vision	☐	☐
Loss of vision	☐	☐
Pain	☐	☐
Redness	☐	☐
Scratchy feeling	☐	☐
Wear contact lenses	☐	☐
Wear glasses	☐	☐
Wear reading glasses	☐	☐
None ☐		

GASTROINTESTINAL		
Abdominal pain	☐	☐
Change in/Painful bowel movements	☐	☐
Nausea/Vomiting	☐	☐
Rectal bleeding/Blood in stool	☐	☐
None ☐		

GENITOURINARY		
Blood in Urine	☐	☐
Burning or painful urination	☐	☐
Female - irregular periods	☐	☐
Frequent urination	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Male - testicular pain	☐	☐
Strain when urinating	☐	☐
None ☐		

HEMATOLOGIC		
Anemia	☐	☐
Bleeding/bruising tendency	☐	☐
Enlarged glands	☐	☐
Past transfusion	☐	☐
Phlebitis	☐	☐
Slow healing	☐	☐
None ☐		

INTEGUMENTARY	YES	NO
Breast lump	☐	☐
Breast pain	☐	☐
Change in hair or nails	☐	☐
Change in skin color	☐	☐
Rash or itching	☐	☐
Varicose veins	☐	☐
None ☐		

MUSCULOSKELETAL		
Back Pain	☐	☐
Cold extremeties	☐	☐
Difficult in walking	☐	☐
Joint pain	☐	☐
Joint stiffness or swelling	☐	☐
Muscle pain or cramps	☐	☐
Weakness of muscles or joints	☐	☐
None ☐		

NEUROLOGICAL		
Convulsions or seizures	☐	☐
Frequent or recurring headaches	☐	☐
Head injury	☐	☐
Light-headed or dizzy	☐	☐
Numbness or tingling sensations	☐	☐
Paralysis	☐	☐
Tremors	☐	☐
None ☐		

PSYCHIATRIC		
Depression	☐	☐
Insomnia	☐	☐
Memory loss or confusion	☐	☐
Nervousness	☐	☐
None ☐		

GRIFFITTS FACIAL & ORAL SURGERY

Patient's Name _____ Today's Date _____

Thank you for choosing Griffitts Facial & Oral Surgery. Our primary mission is to deliver the best and most comprehensive Facial and Oral Surgery care. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options. Our office accepts: Cash/Check, Visa®, MasterCard® or CareCredit Credit Card®[1]

Please note:

1. Upon check-in, payment for services is due in full on the day of your scheduled service.
2. For patients with In-Network Insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement of your treatment.[2]
3. For patients with Out-of-Network Insurance, we will assist you in seeking reimbursement for your treatment by providing you documentation upon request. We do not bill Out-of-Network Insurance carriers.[3]
4. Patients who receive surgery will be scheduled for post-operative visits to promote your recovery process and lower risk of complications.
    a. Minor Surgery post-operative visits and possible imaging are to be scheduled within a 14-day window from date of surgery. These services are included in the cost of your surgery.
        i. All charges for visits performed in relation to a Minor Surgery scheduled after the 14-day window are billable.
        ii. During this 14-day period, any visit not related to the surgery will be considered a billable charge.
    b. Major Surgery post-operative visits and possible imaging are to be scheduled within a 90-day window from date of surgery. These services are included in the cost of your surgery.
        i. All visits performed in relation to a Major Surgery scheduled after the 90-day window are billable.
        ii. During this 90-day period, any visit not related to the surgery will be considered a billable charge.
5. A fee of $50 is charged for missed or canceled appointments occurring more than 3 times in a calendar year without 24 hours' notice (clinic appointments) and 48 hours' notice (scheduled surgery).
6. There is a $30 charge for returned checks.

If you have any questions, please contact the Billing Department (208) 667-0824. We are here to help you get the Facial and Oral Surgery care you need.

_____ _____

Signature of patient, parent, or guardian Date

_____

Printed name of patient, parent, or guardian: Relationship

[1]CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by Griffitts Facial & Oral Surgery or any other healthcare provider. You may apply for the CareCredit healthcare credit card and if approved, use it at Griffitts Facial & Oral Surgery's office. However, the CareCredit credit card agreement is between you and Synchrony Bank. Subject to credit approval.
[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
[3]Payment in full is required at the time of service. We will take care of submitting your Out of Network claim to your insurance company on your behalf. Your insurance company will reimburse/pay you directly should you be owed a refund.

GRIFFITTS FACIAL & ORAL SURGERY

HIPAA[1] AUTHORIZATION FORM

Patient Name: _____ **Date of Birth**: _____

Address: _____ **Phone #:** _____

_____

Patient or guardian authorizes and directs any physician, other health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau or other health care clearinghouse and covered entities[2] that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services (collectively, the "Providers"), to release and disclose the Protected Health Information[3] described herein to the following party(ies) as my agent, to be treated as I would with respect to my rights regarding the use and disclosure of my protected health information.

Please list those individuals whom you give your permission to speak to Griffitts Facial & Oral Surgery in your behalf. **If the individual is not listed below, our office will not be able to communicate with them regarding your treatment or billing in our office.**

Name _____ Relationship _____ Phone #_____

Address _____

Name _____ Relationship _____ Phone #_____

Address _____

Name _____ Relationship _____ Phone #_____

Address _____

A. Limitations on Authorization

Extent of Authorization

I authorize the release of **all** of my protected health information, including: history/physical exam results, progress notes, physician's orders, patient allergies, consultation reports, discharge summaries, pathology reports, operative reports, emergency room record, laboratory reports, x-rays, imaging reports, abstracts or summaries and the contents of medical records.

Period of Health Care Covered by the Authorization

This authorization of the release of my protected information covers all past, present and future protected health information.

Electronic Disclosure

I further acknowledge that any protected health information disclosed pursuant to this authorization may be re-disclosed electronically and consent to the protected health information being disclosed electronically.

[1] The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards and procedures that covered entities must follow when disclosing a patient's protected health information.
[2] Covered entities are defined by HIPAA as health plans, health care clearinghouses and health care providers who conduct certain financial and administrative transactions electronically. These entities are bound by the privacy standards of HIPAA even if they contract with others to perform some of their essential functions.
[3] Under HIPAA, protected health information is individually identifiable information that is created, collected, or transmitted by a HIPAA-covered entity in relation to payment for healthcare services. Protected health information includes, but is not limited to, diagnoses, treatment information, medical test results, prescription information, birth dates, gender, ethnicity, contact and emergency contact information.

Patient's Name _____ Today's Date _____

B. Effective Time Period

This authorization will be in effect until I expressly revoke authorization.

C. Patient Rights and Acknowledgments

i) This release does not affect my ability to obtain treatment, payment, or eligibility for benefits.

ii) I recognize that I have the right to inspect or copy the protected information held by covered entities.

iii) I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent a provider has acted in reliance on it.

iv) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I can request and obtain a copy of the HIPAA Privacy Notice at any time. The date this form is signed is the effective date of this authorization.

_____ _____

Signature of patient, parent, or guardian Date

_____

Printed name of patient, parent, or guardian: Relationship

GRIFFITTS FACIAL & ORAL SURGERY

We're happy to bill all insurances on your behalf, ensuring you receive the benefits *you* deserve.

OUT OF NETWORK INSURANCES:
Our clinic offers claim submission as part of our committment to your care.

- **WHAT WE DO FOR YOU:** We will take care of submitting your Out of Network claim to your insurance company on your behalf, ensuring that all required information is accurately provided while maximizing your benefits available under your policy.
- **WHAT THIS MEANS:** Your insurance company will reimburse/pay you directly should you be owed a refund.

We know that this first step in handling insurance claims can be daunting. By managing this initial submission for you, our goal is to help you get the process started smoothly, allowing you to focus on your health and recovery.

IN NETWORK INSURANCES:
Our clinic offers comprehensive billing support as part of our committment to your care.

- **WHAT WE DO FOR YOU:** We will take care of submitting your In Network claim to your insurance company, ensuring that all required information is accurately provided while maximizing your benefits available under your policy.
    - We will actively follow up with your insurance provider to monitor the status of your claim.
    - We will work with you to provide any additional necessary details your insurance company requires.
- **WHAT THIS MEANS:** Your insurance company will pay our office directly. Should you be owed any refunds after your insurance has paid, our office will issue the refund check to you.

MINOR SURGERIES:

- Patients will be scheduled for a post-operative visit within a 14-day window from the date of surgery.
- This post-operative visit is at no charge and is included in the cost of the surgery when performed within the 14-day window from the date of surgery.
- Possible imaging performed within the 14-day window from the date of surgery is included in the cost of the surgery.
- During this period any visit or imaging not related to the surgery will be considered a billable charge.

MAJOR SURGERIES:

- Patients will be scheduled for post-operative visits within a 90-day window from the date of surgery.
- Including any imaging, these visits are at no charge and are included in the cost of your surgery.
- During this period any visit or imaging not related to the surgery will be considered a billable charge.
- New or existing services or treatment outside of the 14- or 90-day post-operative period is considered a billable charge.

Payment for all services is due in full at the time of check-in.

For questions, please contact the billing department at 208-667-0824.