ROANOKE ORAL SURGERY, INC.
6035 PETERS CREEK ROAD
ROANOKE, VA 24019
(540) 362-5900

ROANOKE ORAL SURGERY, INC.

PRACTICE LIMITED TO ORAL & MAXILLOFACIAL SURGERY

GENERAL INFORMATION

ACCT.#_____

PATIENT FULL NAME: _____ **DATE OF BIRTH:**_____

Mailing Address: _____City _____ State_____ Zip _____

Street Address:_____City _____ State_____ Zip _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Age: _____ Sex: _____ Marital Status: _____ SSN:_____

Patient Employed By: _____ How Long?_____ Occupation: _____

Employer's Address: _____ Phone: _____

Parent/Spouse Name (Click One): _____ How Long?_____ Occupation: _____

Parent/Spouse Employed by: _____ Phone: _____

Person Responsible for patient's bill: _____ SSN:_____

Relation to patient: _____ Address: _____ Employer: _____

Person to notify in case of emergency (if different from above): _____

Phone (during the day): _____ Relationship: _____

Have you ever been a patient here before? _____ Approximate Date: _____

Have any members of your family been patients here before?____ Name: _____ Approx. Date:_____

Family Dentist: _____ Orthodontist: _____

Family Physician: _____ Who referred you to this office? _____

INSURANCE INFORMATION

IN ORDER FOR US TO PROPERLY FILE A CLAIM FOR SERVICES RENDERED IN OUR OFFICE, THE FOLLOWING INFORMATION MAY BE SUPPLIED.

DO YOU HAVE DENTAL INSURANCE? ☐Yes ☐No Relationship of patient to policyholder: ☐Self ☐Spouse ☐Child

Name of Dental Insurance Company: _____

ID. # of Policyholder:_____ Group #:_____

Name of Policyholder: _____ Date of Birth: _____

Policyholder's Place of Employment: _____

DO YOU HAVE MEDICAL INSURANCE? ☐Yes ☐No Relationship of patient to policyholder: ☐Self ☐Spouse ☐Child

Name of Medical Insurance Company: _____

ID. # of Policyholder:_____ Group #:_____

Name of Policyholder: _____ Date of Birth: _____

Policyholder's Place of Employment: _____

IF WE PARTICIPATE WITH YOUR INSURANCE YOU WILL BE REQUIRED TO PAY ALL COPAYS AND UNMET DEDUCTIBLES AT THE TIME OF SERVICE. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE. IF YOU PROVIDE A COPY OF YOUR INSURANCE CARD WITH ALL PERTINENT INFORMATION, AS A COURTESY, WE WILL FILE YOUR INSURANCE CLAIM FOR YOU. BY SIGNING BELOW YOU ARE AUTHORIZING ASSIGNMENT OF INSURANCE BENEFITS, PAYABLE TO YOU ON YOUR BEHALF, TO ROANOKE ORAL SURGERY, INC. THIS SIGNATURE SERVES AS A REQUEST FOR PAYMENT FOR SERVICES RENDERED BY ALBERT W. PARULIS, JR. D.M.D., JASON I. MARGOLIS, D.M.D. OR KAINE K.S. STOKES, D.D.S. YOUR SIGNATURE BELOW ALSO AUTHORIZES THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS YOUR INSURANCE CLAIM.

FOR YOUR CONVENIENCE, WE ACCEPT MASTERCARD, VISA, & DISCOVER. A MINIMUM FINANCE CHARGE OF FIFTY CENTS PER MONTH OR FINANCE CHARGES AT THE RATE OF 1% PER MONTH (12 APR) WILL ACCRUE ON ANY UNPAID BALANCE 90 DAYS FROM THE DATE OF SERVICE IN THE EVENT THAT IT BECOMES NECESSARY TO TURN YOUR ACCOUNT OVER TO OUR ATTORNEY FOR COLLECTION, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL OF YOUR ACCOUNT PLUS ALL THE COLLECTION COSTS AND 33% ATTORNEY'S FEES.

_____

DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT IF MINOR

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MEDICAL INFORMATION

PATIENT FULL NAME: _____ **DATE OF BIRTH:**_____

What complaint brought you to this office? _____

Give Details :_____

Please Check the appropriate box only if you have any of the following conditions:

- ☐ AIDS (HIV Infection)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chest Pain (Angina)
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease (or Heart Attack)
- ☐ Heart Murmur
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease (Cirrhosis or Hepatitis)
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Malignant Hyperthermia
- ☐ Nervous Disorder
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease or Trait
- ☐ Sleep Apnea/CPAP
- ☐ Stomach or Intestinal Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Venereal Disease

	YES	NO
Are you allergic to any medication or materials such as latex? If yes, please list: _____	☐	☐
Do you use biphosphonates such as Fosamax, Actonel, etc. ? (These drugs are generally employed orally for osteoporosis and sometimes intravenously for malignancy).	☐	☐
Have you taken or are you taking steroids (cortisone, prednisone)?	☐	☐
Are you taking any anticoagulants (blood thinners)? Please list: _____	☐	☐
Are you presently under the care of a physician, including pain management? Physician's Name:_____ Why?_____	☐	☐
Are you take any medications or drugs? Please list names & dosages of each drug:_____ _____ _____	☐	☐
Do you have any abnormal growths in your mouth? Present how long?_____	☐	☐
Do you smoke cigarettes/cigars? If yes, for how many years?_____ How many cigarettes/cigars used a day? _____	☐	☐
Do you use smokeless tobacco or chewing tobacco?	☐	☐
Have you had any major surgery or serious illness? Please list and provide dates: _____ _____ _____	☐	☐
Are you pregnant? If so, how many months?_____ Physician: _____	☐	☐
Are you now or have you been under psychiatric care?	☐	☐
Have you ever received therapeutic radiation for the treatment of a head/neck tumor?	☐	☐
Have you or any member of your family ever had a complication from a local or general anesthetic?	☐	☐
Do you wear contact lenses?	☐	☐
Do you now or have you ever used alcohol or other drugs in excess?	☐	☐

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE MEDICAL INFORMATION I HAVE PROVIDED IS ACCURATE AND COMPLETE.

_____

DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT IF MINOR