# Triangle Oral & Maxillofacial Surgery
# David M. Lambert, DDS, PA

Patient's Name ______________________________________________ Age: _____ Birthdate: _________ Phone: _________

Street Address: ______________________________________________ City: _______________ State: _____ Zip: _________

Employed by: ________________________________Address: ___________________________ Occupation: ____________

City: __________________________________________ State: _____ Zip: _________ Phone: (         ) - _______________

Drivers License No: ____________________ Social Security No: ___________________ Email: ______________________

Parent or Spouse: ___________________________________________ Phone: ____________________ Birthdate: ________

Employed by: ________________________________________ Address: __________________________________________

City: __________________________________________ State: _____ Zip: _________ Phone: (         ) - _______________

How do you plan to pay: cash/check: _______ CC: _______ Payment Plan: _______

## HEALTH INSURANCE INFORMATION

Dental Insurance Co: ____________________________________________ Policy No: _______________________________

Medical Insurance Co: ___________________________________________ Policy No: _______________________________

PERSON RESPONSIBLE FOR FEE: Patient _____ Parent _____ Spouse _____ Other (Name) ____________________________

## INSURANCE AND FEES

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES FOR SERVICES COVERED BY INSURANCE. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CHECKS, AND CASH. Your signature below indicates that you understand and accept this policy. Also, your signature anthorizes Triangle Oral and Maxillofacial Surgery (TOMS) to release such medical and/or dental information to process your insurance claim (if any), and also to share your medical/dental information with other authorized health care practitioners.

I hereby authorize TOMS to furnish my insurance company all information, which said company, may request concerning my present illness or injury. I hereby assign to TOMS all sums payable to me from the amount of money to which I am entitled for medical and or surgical expenses. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THOSE CHARGES NOT PAID BY MY INSURANCE. I agree that a photocopy of this, my original authorization, shall be considered equally authentic.

The fee for your treatment is determined by the complexity of your case. It is our policy that all fees are paid on the day of surgery. PLEASE BE ADVISED TOMS RESERVES THE RIGHT, AT THEIR DISCRETION, TO MAKE CHARGES FOR TIME SPENT DIRECTLY OR INDIRECTLY IN THE AUTHORIZED PURSUIT OF YOUR CARE. ANY FEE OR PORTION OF FEE UNPAID 30 DAYS AFTER COMPLETION OF SURGERY IS SUBJECT TO A LATE FEE OF 1.5% PER MONTH (18% PER ANNUM), OR $10 PER MONTH, WHICHEVER IS GREATER. SHOULD LEGAL ACTION BE REQUIRED TO SECURE PAYMENT, YOU WILL BE CHARGED A REASONABLE ATTORNEY'S FEE OF 15% OF ANY AMOUNT OUTSTANDING AS WELL AS BEING CHARGED FOR ANY COURT FEES AND INTEREST.

Should the account become past due more than 60 days, I authorize the unpaid balance to be charged to my major credit card as listed below.

( ) Visa ( ) MasterCard ( ) American Express ( ) Discover

________________________________________ ____________________________
CARD # EXP. DATE

________________________________________ ____________________________
NAME AS IT APPEARS ON CARD SIGNATURE

________________________________________
DATE

CHARGES FOR CANCELLATION OF APPOINTMENTS AND SURGERIES

If for any reason you fail to show up for a scheduled appointment or surgery, you will be charged in full for the time or procedure scheduled unless you provide written notice to this office 48 hours in advance of the scheduled appointment or surgery. I also understand my appointment may be cancelled if I am 15 minutes or more late for any appointment.

I have read the above statements,understand them,
and agree to the terms as stated.

_______________________________________________________
SIGNED PATIENT OR PARENT IF MINOR DATE

# Medical and Health History Questionnaire

Who referred you to this office? ______________________________

The name and phone number of my physician is ______________________________

The name and phone number of my dentist is ______________________________

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

**Have you ever:**

| | YES | NO |
|---|---|---|
| Had a serious illness? | ☐ | ☐ |
| Been hospitalized in the last 5 years? | ☐ | ☐ |
| Had a surgery or an operation in the past? | ☐ | ☐ |
| Received doctor's care in the past 6 months? | ☐ | ☐ |
| Had excessive bleeding after a surgery? | ☐ | ☐ |
| Had a blood transfusion? If so when? | ☐ | ☐ |
| Had periods of unconsciousness or fainting spells? | ☐ | ☐ |
| Had a problem with local or general anesthesia? | ☐ | ☐ |
| Been immunosuppressed or have problems of the immune system? | ☐ | ☐ |
| Been treated for an alcohol or drug usage problem? | ☐ | ☐ |

**Are you:**

| | YES | NO |
|---|---|---|
| Presently wearing contact lenses? | ☐ | ☐ |
| Allergic to latex or rubber products or tape materials? | ☐ | ☐ |

Allergic to any drug or medication?

Please list drug allergies: ______________________________

Any other allergies? ______________________________

| | YES | NO |
|---|---|---|
| Taking or have you taken prescription medications or drugs for weight loss? | ☐ | ☐ |

What medications (including non-prescription) are you currently taking? ______________________________

______________________________

What herbal medications are you taking? ______________________________

______________________________

| | YES | NO |
|---|---|---|
| Do you currently smoke or chew tobacco products? | ☐ | ☐ |
| Did you smoke or chew tobacco products in the past? | ☐ | ☐ |

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

| | YES | NO |
|---|---|---|
| Seizure disorders/epilepsy/convulsions? | ☐ | ☐ |
| Migraine headaches? | ☐ | ☐ |
| Stroke or Transient ischemic attacks (TIA's)? | ☐ | ☐ |
| Mental health problems, psychiatric disorders, or panic disorder? | ☐ | ☐ |
| Glaucoma? | ☐ | ☐ |
| Facial trauma? | ☐ | ☐ |
| Sinus or nasal problems? | ☐ | ☐ |
| Hay fever? | ☐ | ☐ |
| TMJ problems (pain near the ear, clicking or popping of the jaw joint, difficulty opening the mouth)? | ☐ | ☐ |
| Heart problems, cardiovascular disease, angina or chest pain? | ☐ | ☐ |
| Blood pressure problems (high or low)? | ☐ | ☐ |
| Swelling of feet or ankles? | ☐ | ☐ |
| Shortness of breath? | ☐ | ☐ |
| Heart murmur? | ☐ | ☐ |
| Rheumatic fever or rheumatic heart disease? | ☐ | ☐ |
| Heart valve replacements? | ☐ | ☐ |
| Congenital heart defect? | ☐ | ☐ |
| Asthma/Emphysema? | ☐ | ☐ |
| Hepatitis/jaundice or liver disease? | ☐ | ☐ |
| Stomach ulcers, gastritis, acid reflux, or hyperacidity? | ☐ | ☐ |
| Colitis, diverticulitis or Crohn's disease? | ☐ | ☐ |
| Kidney disease? | ☐ | ☐ |
| Thyroid disease? | ☐ | ☐ |
| Diabetes? | ☐ | ☐ |
| Spleen removal? | ☐ | ☐ |
| HIV / AIDS? | ☐ | ☐ |
| A blood disorder (i.e., white or red blood cell, or platelet abnormality)? | ☐ | ☐ |
| Bleeding or clotting problems? | ☐ | ☐ |
| Anemia or sickle cell anemia? | ☐ | ☐ |
| Arthritis? | ☐ | ☐ |
| Hip or knee replacements? | ☐ | ☐ |
| Cancer (now or in the past)? | ☐ | ☐ |
| Radiation therapy or x-ray treatments for cancer? | ☐ | ☐ |
| Cortisone or steroid therapy? | ☐ | ☐ |
| Implants, transplants, or synthetic grafts placed anywhere in the body? | ☐ | ☐ |
| Substance abuse problems? | ☐ | ☐ |