Oral & Maxillofacial Surgery of Greater Grand Rapids, PLLC
Dr. Bradley VanHoose DDS, MS
Patient Registration Information

Name _____ Soc. Sec. #_____
Last Name First Name Initial

Address _____ City _____ State ____ Zip _____

Home Phone #_____ Cell Phone # _____ Other _____

Sex: Male___ Female___ Age_____ Date of Birth _____ Drivers Lic. #_____

Employer _____ Business Phone #_____

Dentist _____ Referring Doctor_____

Emergency Contact _____Phone # _____

Responsible Party: (If minor or legal guardian) Relationship To Patient _____

Name _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Date of Birth _____ Drivers Lic. #_____ Soc. Sec. #_____

Employer _____ Employer Phone # _____

Primary Dental Insurance:

Insurance Co._____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Address if different than patients _____

Secondary Dental Insurance:

Insurance Co._____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Primary Medical Insurance:

Insurance Co._____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Address if different than patients _____

Secondary Medical Insurance:

Insurance Co._____ Group # _____

Address _____ Phone # _____

Employer _____ Employer Phone # _____

Employee _____ Soc. Sec. # _____ Date of Birth _____

Name of High School or College _____Full ____ Part Time ____

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Medical History:

Physician's Name_____ Date of Last Visit _____

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Are you under any treatment now? Yes No If yes, describe _____

Have you ever had a problem with anesthesia? Yes No If yes, describe_____

Are you taking any medication? (including non-prescription medication)

Yes No If yes, describe _____

Do you use tobacco? Yes No Do you use controlled substance? Yes No Do you wear contact lenses? Yes No

Persistent cough or throat clearing not associated with a known illness lasting more then (3) weeks? Yes No

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (√) if you have or have had any of the following:

__ AIDS	__ Cortisone Treatments	__ Hepatitis	__ Rheumatic Fever
__ Anemia	__ Cough, Persistent	__ High Blood Pressure	__ Scarlet Fever
__ Arthritis, Rheumatism	__ Cough Up Blood	__ HIV Positive	__ Shortness of Breath
__ Artificial Heart Valves	__ Diabetes	__ Jaw Pain	__ Skin Rash
__ Artificial Joints	__ Epilepsy	__ Kidney Disease	__ Stroke
__ Asthma	__ Fainting	__ Liver Disease	__ Swelling of Feet/Ankles
__ Back Problems	__ Glaucoma	__ Mitral Valve Prolapse	__ Thyroid Problems
__ Blood Disease	__ Headaches	__ Nervous Problems	__ Tobacco Habit
__ Cancer	__ Heart Murmur	__ Pacemaker	__ Tonsillitis
__ Chemical Dependency	__ Heart Problems	__ Psychiatric Care	__ Tuberculosis
__ Chemotherapy	Describe_____	__ Radiation Treatment	__ Ulcer
__ Circulatory Problems	__ Hemophilia	__ Respiratory Disease	__ Venereal Disease

Are you allergic to or have you had any reactions to medications, latex or metals? Yes No

If yes, describe _____

Dental History:

Dentist Name_____ Date of Last Visit _____

Do you feel any pain now in your mouth, teeth or jaw areas? Yes No If yes, describe _____

Have you had any head, neck or jaw injuries? Yes No If yes, describe _____

Are you experiencing or have you experience any of the following problems in your jaw?

Clicking? Yes No Pain? Yes No Difficulty opening or closing? Yes No

Do you clench or grind your teeth? Yes No

Have you ever had any difficult extractions in the past? Yes No

Have you ever had any prolonged bleeding following extractions? Yes No

Do you have any sores or lumps on or in your mouth? Yes No

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Authorization and Release:

I certify that I have read and understand all of the information contained in this form to the best of my knowledge. That all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the oral surgeon to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon or practice insurance benefits otherwise payable to me. I understand that my dental/medical insurance carrier may pay less than the actual amount for services rendered on behalf of myself or dependants.

*If you have any questions or need assistance, please ask us and we will be happy to help.**

Do not sign or date this form until it has been reviewed by our office staff or oral surgeon.

_____
Please print name

X_____ Date: _____
Signature of patient (or parent/guardian if minor)

For office use only:

Date form completed:_____ Reviewed by: _____

Notes:_____

Oral Surgeon Comments:

_____

_____

_____

_____

_____

Oral Surgeon:_____ Date:_____

* This on-line form is available for you to download, print. and fill out at your convenience. Please fill out completely (in ink) and bring it with you at your scheduled appointment time. To safeguard your personal and health information **do not** E-mail, Fax or electronically transmit this information to our office or any third party. Thank you.

Oral & Maxillofacial Surgery of Greater Grand Rapids, PLLC
9021 North Rodgers Dr., Suite A Caledonia, MI 49316 (616) 891-1700

Medicare Opt-Out Private Contract

This contract between Dr. Bradley VanHoose and _____ allows Dr. Bradley VanHoose to provide treatment to the above patient without being subject to Medicare limits. To do so, the law requires Dr. Bradley VanHoose to "opt-out" of Medicare and that no Medicare claim be filed for the treatment of the above patient by Dr. Bradley VanHoose.

Dr. Bradley VanHoose represents that Dr. VanHoose is excluded from participation under the Medicare program under 1128, 1156 or 1892 of the Social Security Act; in addition, the above patient and Dr. VanHoose agree that the above patient is not now facing an emergency or urgent health care situation.

By signing this contract, Patient does the following:

1. Agrees **not** to submit a Medicare claim (or to request that Dr. Bradley VanHoose submit a claim) for services or items supplied by Dr. Bradley VanHoose, even if they are otherwise covered under Medicare.

2. Agrees to be responsible, whether through insurance of otherwise, for payment of services or items supplied by Dr. Bradley VanHoose, and understands that no reimbursement will be provided under Medicare for those services or items: in particular, the above patient will pay for such services at Dr. Bradley VanHoose's usual rate (or any other agreed upon rate), in accordance with Dr. Bradley VanHoose's payment policies.

3. Acknowledges that Medicare limits do not apply to amounts that Dr. Bradley VanHoose may charge for such services or items.

4. Acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services covered by this contract, because payment is not made under Medicare, and

5. Acknowledges that the above patient has the right to have such services or items provided by other dentists or practitioners for whom payment would be made under Medicare. (Patient is not required to enter into private contracts that apply to other Medicare covered services furnished by other dentists who have opted out.)

This contract shall remain in force and effect from the date it is signed by the above patient until the end of the term of Dr. Bradley VanHoose's current opt-out period. The expiration date of Dr. Bradley VanHoose's opt-out period is January 9, 2020.

Accepted and Agreed _____ _____
Dr. Bradley VanHoose Date

Accepted and Agreed _____ _____
Patient or Patients legal representative Date

Original contract to be retained by dentist, a copy will be provided to the patient upon request.

ORAL & MAXILLOFACIAL SURGERY
OF GREATER GRAND RAPIDS, PLLC
Bradley VanHoose, DDS, MS
9021 North Rodgers Dr., Suite A
Caledonia, MI 49316
616-891-1700 Phone
616-891-9306 Fax

FINANCIAL AGREEMENT

Payment in full is due on the day of surgery, if you do not have any insurance.

In cases of divorced parents, the parent bringing the child will be deemed responsible for payment.

If you do have insurance we will attempt to call your insurance to access your benefits and **estimate** your portion due the day of surgery. The actual patient responsibility may vary depending on the amount your insurance company pays. Insurance companies do not guarantee payment or the amount they will pay. If we are unable to access your insurance benefits, you will be responsible for the entire fee. You are responsible, however, for all fees incurred in the event insurance is denied. All co-pays & deductibles are due on the day of surgery. Dr. Bradley VanHoose is a nonparticipating provider for all Blue Cross Blue Shield and Blue Care Network **medical** plans (this does NOT include MESSA or the BCBS dental insurance). You are responsible for all charges the day of service and we will submit a claim on your behalf. You will be reimbursed directly from Blue Cross Blue Shield their reasonable and customary amount.

I understand I will be responsible for any amount not paid by my insurance company.

Estimates are based on the plan benefits that have been released to us and are subject to the conditions of the plan on the day the charges are incurred. **Any amounts quoted are only estimates and not a guarantee of benefits paid by your insurance.**

As an accommodation to you we will submit a claim on your behalf. Please remember the contract is between you and your insurance company, not our office and your insurance company. If you have questions regarding your insurance plan we do recommend you contact your insurance company directly or contact your human resource department of the employer/company offering your insurance benefits.

Occasionally, dental insurance companies require a denial from your medical carrier before processing your claim. If this denial is not received in our office within 30 days of the date of surgery you will be held responsible for the balance due.

If payment from your insurance is not received within 60 days of the date services are rendered, we reserve the right to bill you directly and hold you responsible for the entire balance due.

If insurance coverage is denied, your account must be paid in full within 30 days of invoice. Accounts not paid within 30 days will be subject to a 10% rebilling fee on the account balance. Any balance not collected within 60 days will be referred for collection/court with attorney fees assessed.

I understand and agree to the above financial policy.

_____ _____

Signature of Patient or Parent/Guardian if Minor Date

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14,2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving or offering you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign *this form below under the heading "acknowledgement" to acknowledge that you have today received, or have been offered, a copy of our notice of privacy practices.*

I acknowledge that I have today received, ***or have been offered,*** a copy of the Notice of Privacy Practices.

X_____ _____

Patient Signature or Legal Guardian if the patient is under 18 Patient Name (Please Print)

Date:_____

Please list the family members or significant others & phone #, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:** _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____

Patient Consent

Please sign *this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.*

I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

X_____ _____

Patient Signature or Legal Guardian if Patient is under 18 Patient Name (Please Print)

Date:_____