GERMANTOWN
ORAL & FACIAL SURGERY

19717 Executive Park Circle
Germantown, MD 20874
Ph: (301) 916-0486
Fax: (301) 916-0489
www.GermantownOralSurgery.com
Email: **GermantownOFS@gmail.com**

Kenneth J. Wu DDS ∞ **Mathew K. Woodward DDS** ∞ **Zachary D. Saltman DMD**

Patient Information (Confidential)

Today's Date_____

Name (First)_____(M.I.)_____(Last)_____

Date of Birth_____Age_____Social Security #_____

Status (circle): Minor Single Married Separated Divorced Widowed

Gender Identity (**circle or fill in the blank**): Female Male _____

Mailing Address_____

City_____State_____Zip Code_____

Phone # (**circle preferred**) Home_____Cell_____Work_____

Email:_____

Patient's Employer_____

Parent's / Legal Guardian's Name_____Relationship_____

Primary Dentist_____Specialist Dentist_____

Physician_____Phone #_____

Emergency Contact Name & Relationship_____Phone #_____

Insurance Policy Information

(Unable to process insurance claims without this information)

Primary Dental Insurance

Insurance Carrier Name_____

Policy/ID #_____

Group #_____

Policyholder's Name_____

Date of Birth_____SS #_____

Relationship to Patient_____

Employer_____

Work Phone_____

Primary Medical Insurance

Insurance Carrier Name_____

Policy/ID #_____

Group #_____

Policyholder's Name_____

Date of Birth_____SS #_____

Relationship to Patient_____

Employer_____

Work Phone_____

Secondary Dental Insurance (If Applicable)

Insurance Carrier Name_____

Policy/ID #_____

Group #_____

Policyholder's Name_____

Date of Birth_____SS #_____

Relationship to Patient_____

Employer_____

Work Phone_____

Secondary Medical Insurance (If Applicable)

Insurance Carrier Name_____

Policy/ID #_____

Group #_____

Policyholder's Name_____

Date of Birth_____SS #_____

Relationship to Patient_____

Employer_____

Work Phone_____

*****I certify with my signature that the information provided above is accurate and complete to the best of my knowledge*****

Patient's (or Guardian's) Signature **Date**

GERMANTOWN
ORAL & FACIAL SURGERY

Health Questionnaire

Name:_____ **Birth Date:**_____ **Height:**_____ **Weight:**_____ **(lbs)**

Please answer ALL questions by checking Yes (Y) or No (N). ANSWERS ARE STRICTLY CONFIDENTIAL

☐Y ☐N Are you under the care of a physician? Last physical exam date:_____

☐Y ☐N Have you *ever* had any operation, procedure, sedation, serious illness or been hospitalized? List with Dates:_____

_____

☐Y ☐N Do you smoke tobacco or E-cigarettes/Vape? How many/often per day:_____

☐Y ☐N Do you drink alcoholic beverages? How much:_____ How often:_____

☐Y ☐N Do you use marijuana or its derivatives in any form? Frequency per week:_____ Last used:_____

☐Y ☐N Have you ever used recreational drugs (cocaine, LSD, meth, ketamine, ecstasy, hallucinogens, etc.)?
Circle/List each:_____ Last used:_____

☐Y ☐N Have you ever been treated for alcohol / substance abuse? **Circle**/List substance(s):_____

Are you taking any of the following?

☐Y ☐N Antibiotics: List:_____ Start date:_____

☐Y ☐N Pain medications in the past 3 months (Vicodin, Oxycontin/Oxycodone/Percocet, Codeine, Morphine, Fentanyl, etc.)
Circle/List:_____ Reason:_____

☐Y ☐N Methadone, Buprenorphine/Suboxone/Subutex

☐Y ☐N Anticoagulants/blood thinners (ex. Plavix, Coumadin/Warfarin, Pradaxa, Xarelto, Eliquis, Aspirin)
Circle/List:_____ For Warfarin/Coumadin, Recent INR:_____ Date:_____

☐Y ☐N Blood pressure, Heart medicine, Nitroglycerin. **Circle/List**:_____

☐Y ☐N Steroids: Cortisone, Prednisone, other:_____

☐Y ☐N Insulin or Diabetes medication. List:_____

☐Y ☐N Diet pills, now or in the past: Fen-Phen, Redux, Phentermine, Dexfenfluramine, other:_____

☐Y ☐N Have you ever taken Bisphosphonates, pills or injections for osteoporosis or chemotherapy: Actonel, Aredia, Boniva, Fosamax, Prolia, Reclast, Zometa, other:_____ Last dose:_____ Taken how long:_____

List ***ALL other medication/inhalers/vitamins/supplements you are taking/prescribed:_____

_____

☐Y ☐N ☐N/A Are you pregnant or trying to become pregnant, or are you nursing (please **circle** if appropriate)?

ALLERGIES: Are you **ALLERGIC** to or have you reacted adversely to: (**Circle** items as appropriate, and ***describe the reaction***)

☐Y ☐N Penicillin, Amoxicillin, Augmentin, Clindamycin, or other antibiotics?_____

☐Y ☐N Local Anesthetic (Lidocaine, Novocain, etc.)?_____

☐Y ☐N NSAIDs, Ibuprofen/Motrin/Advil, Naproxen/Aleve, Aspirin, Tylenol/Acetaminophen?_____

☐Y ☐N Opioids (Codeine, Tramadol, Oxycodone / Percocet, Hydrocodone / Vicodin, Fentanyl, Morphine)?_____

☐Y ☐N Soybean or egg?_____

☐Y ☐N Barbiturates, sedatives, sleeping pills?_____

☐Y ☐N Iodine, Seafood, Shrimp?_____

☐Y ☐N Latex, adhesives, or tape?_____

LIST ALL OTHER DRUG/FOOD ALLERGIES:_____

☐Y ☐N Do you have a history (or any family history) of Malignant Hyperthermia?

☐Y ☐N Have you or any family members had complications with anesthesia? Explain_____

Do you have or have you ever had any of the following issues?

HEAD & MOUTH (**check & circle** where appropriate)

☐Y ☐N Do you gag easily, or do you have difficulty swallowing pills?

☐Y ☐N TMJ (jaw joint) pain/clicking/popping/dislocation or restriction on opening? (**Circle** which)

☐Y ☐N Do you routinely require antibiotics before dental work?

☐Y ☐N Complications or abnormal bleeding with past dental / surgical treatment? Explain:_____

☐Y ☐N Radiation to the Head or Neck for cancer or tumor treatment?

BLOOD (**check & circle** where appropriate)

☐Y ☐N Bleeding Disorders: Hemophilia, Von Willebrand, DVT, Pulmonary Embolism, family history, other:_____

☐Y ☐N Anemias: Iron, sickle cell, platelets, other:_____

☐Y ☐N Leukemia, Lymphoma, Multiple Myeloma

☐Y ☐N Blood transfusion? Date:_____ Why:_____

ENDOCRINE

☐Y ☐N Diabetes: **Circle** type ***I*** or ***II***. Recent A1C level:_____ Average morning blood sugar range:_____

☐Y ☐N Thyroid Disorders/procedures: List:_____

HEART & CIRCULATION (**check & circle** where appropriate)

☐Y ☐N *High* or *Low* Blood Pressure? (**Circle** which)

☐Y ☐N Chest Pain, Angina, Heart Attack? How many times:_____When was last event:_____

☐Y ☐N Coronary Artery Disease, Aortic Stenosis, Carotid Artery Stenosis, Aneurysms, other:_____

☐Y ☐N Murmur (**Circle** *Current* or in the *Past*), Endocarditis, Pericarditis, Heart Failure, other:_____

☐Y ☐N Irregular Heart Beat: Tachycardia, POTS, SVT, A-fib, Heart Block, WPW, other:_____

☐Y ☐N Stents placed? Heart or other places: List:_____How many:_____Dates:_____

☐Y ☐N Heart Surgeries: Bypass, Valve(s) Replaced, Defibrillator, Pacemaker, LVAD, other:_____

☐Y ☐N High Cholesterol

☐Y ☐N Family History of Heart Disease or other issues not listed above:_____

LUNGS & BREATHING (**check & circle** where appropriate)

☐Y ☐N Seasonal/Environmental Allergies or Sinus problems (**circle** which)? Triggered by:_____

☐Y ☐N Asthma (**Circle**: *Current* or in the *Past)*. Rescue inhaler uses per week? #_____ Triggered by:_____

☐Y ☐N Chronic Coughing or Chronic Bronchitis, Emphysema, COPD, other:_____

☐Y ☐N Any cough / congestion / fevers in the last 4 weeks?

☐Y ☐N Heavy snoring or Sleep Apnea (**circle** which)? Mild / moderate / severe; CPAP setting: #_____

LIVER (**check & circle** where appropriate)

☐Y ☐N Hepatitis, Cirrhosis, Jaundice, Gallbladder or Liver Disease:_____

KIDNEY (**check & circle** where appropriate)

☐Y ☐N Kidney failure (**Circle** *Acute* or *Chronic*) (if Chronic, stage: #_____) or Dialysis (peritoneal / hemodialysis)

☐Y ☐N Kidney or Urinary Problems and/or Procedures: List & Dates:_____

GASTROINTESTINAL (**check & circle** where appropriate)

☐Y ☐N GERD (heart burn/indigestion), Stomach Ulcers, Esophagitis

☐Y ☐N C. Difficile infection

☐Y ☐N Colitis or Other problems: List:_____

BRAIN & NERVES (**check & circle** where appropriate)

☐Y ☐N Fainting spells or syncope: Frequency:_____Date of last episode:_____

☐Y ☐N Stoke or TIA: Dates:_____

☐Y ☐N Seizures or Epilepsy: Type of seizures:_____Frequency:_____Last episode:_____

☐Y ☐N Chronic Pain conditions: Neck, Back, Fibromyalgia, CRPS, RDS, Migraines, other:_____

☐Y ☐N Neuropathies/Numbness: Where:_____

☐Y ☐N Psychiatric Illness: ADD/ADHD, Anxiety, Depression, Bipolar, Psychoses, Anorexia, Bulimia, other:_____

MUSCLES & BONES (**check & circle** where appropriate)

☐Y ☐N Arthritis: Osteo, Rheumatoid, other:_____

☐Y ☐N Osteoporosis or Osteopenia (**circle**)

☐Y ☐N Artificial Joint Replacements: What joint(s) & Date(s): _____

☐Y ☐N Connective tissue disorders: Ehlers-Danlos, Marfan, other:_____

☐Y ☐N Muscle disorders or weakness: What type/Where:_____

OTHER (**check & circle** where appropriate)

☐Y ☐N Sexually Transmitted Diseases: List_____

☐Y ☐N Autoimmune Disorders

☐Y ☐N Recurrent or resistant infections: Tuberculosis, MRSA, other:_____

☐Y ☐N History of any Organ/Tissue Transplants: List:_____

☐Y ☐N Cancer/tumors of any type:_____

☐Y ☐N Glaucoma

☐Y ☐N Do you wish to talk to the doctor privately about anything else?

☐Y ☐N Are there any other diseases, conditions, or problems not listed that the doctor should know about?_____

_____

*****I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I further acknowledge that ***it is my responsibility*** to inform my doctor(s) of any changes with my health, medications, and allergies while under treatment. I will not hold The Doctors of Germantown Oral and Facial Surgery Center, or any member of their staff, responsible for any errors or omissions that I have made in the completion of this form or failure to inform them of changes with my health, medications, and allergies while under treatment. ******

_____ _____

Signature of person completing this form & **relation to patient** Date Signature of Doctor Date

GERMANTOWN
ORAL & FACIAL SURGERY

Privacy Practice Notice

I hereby acknowledge that a copy of Germantown Oral & Facial Surgery Center's Privacy Practice Notice has been made available to me (available on the website and in the waiting room). I have been given the opportunity to ask questions I may have regarding this notice. I understand that this acknowledgement shall remain in effect from this time forward, and that I may change my preferences at any time by completing this form again.

1) I hereby consent to be contacted in the following manner (**initial** all that apply)

_____Home Phone _____Cell Phone _____Work Phone _____Email

2) Please **initial** ONLY one:

_____OK to leave a message with detailed information

_____Only leave a message with a call-back number

3) I allow you to give my clinical information to or answer questions from (**initial** all that apply)

_____Spouse (name): _____

_____Parents (name/s): _____

_____Child/children (name/s): _____

_____Other (specify): _____

_____None

Signature of patient/guarantor Printed Name Date

Witness (Germantown Oral & Facial Surgery Staff) Date

GERMANTOWN
ORAL & FACIAL SURGERY

Financial Policy Disclosure & Agreement

Thank you for choosing Germantown Oral & Facial Surgery Center for your oral surgical care. We are committed to providing the highest standard of care at a reasonable cost. In order to avoid any misunderstandings, we ask that you review and sign our financial policies disclosure prior to agreeing to treatment.

Estimates for surgical services or verification of insurance coverage will only be provided after meeting with one of our surgeons to determine a treatment plan and becoming an established patient. This is the only way to ensure you receive accurate and appropriate information and care. Out of this concern for accuracy and transparency, we do not perform treatment unless we have provided you with an estimate of your fees. Please call us should you have any questions after receiving your estimate and we will gladly explain the breakdown of fees.

As a courtesy prior to scheduling your consultation, patients have requested understanding what the

maximum out-of-pocket expenses could be (your insurance may or may not cover a portion) for a:

Dental specialist consultation	$130
Medical specialist consultation (lesion or biopsy)	$232
Panoramic radiograph	$155
CT of the jaw(s)	$250 - 450

This practice participates with many different insurance carriers and their various plans. We try to keep up with the terms of each, but this is not always possible. We will work to maximize your insurance reimbursement for those procedures covered by your insurance plan. **You are ultimately responsible for the payment of any remaining balance not covered by your insurance**. It is your responsibility to know and understand your insurance policy and benefits as you are the one who has a contract with the insurance carrier. Nevertheless, as a courtesy, we will attempt to verify the insurance coverage, calculate an estimate of your financial responsibility, and provide you with this information before the day of surgery. The estimate is based solely on the information provided to us by you and your insurance carrier, and are not a guarantee from our office or the insurance carrier regarding the actual covered benefit for treatment. **Actual benefits will be determined by your insurance carrier after the claim is submitted**. We cannot and will not be responsible for any incorrect information provided to us by you or the insurance carrier. If you are concerned with the coverage, the safest thing to do is to check with the insurance carrier yourself or have us request a *pre-determination of coverage*. Please note that the insurance carriers consistently take 6 weeks or more to respond once we have submitted the pre-determinations request.

Even if prior authorization or a pre-determination is obtained, any insurance carrier has the ability to deny payment at a later date, claiming that the procedure is non-covered or not medically necessary. This might be due to an error on their part, an exclusion in the policy, or because of a change in the policy between the time the coverage is verified and the time the surgery is performed. It is also possible for the insurance carrier to determine that the coverage is no longer valid on the date that the surgery is performed. Should any of these unforeseen occurrences take place, you will become responsible for the full charges, regardless of what the initial estimate may have been. Denials by the insurance carrier are your responsibility to appeal for coverage. We do not file appeals. We will be glad to provide the treatment notes and information in order to file the appeal.

All payments are due and payable at the time of service. This includes charges for X-rays, co-pays, and surgical treatment. Our fees reflect the quality of care that we endeavor to give to each patient; as such, they are not negotiable.

Payment options:

- Cash, Check, Visa, Mastercard, Discover, American Express, HSA, FSA
- Returned check: a $100 fee will be charged to the patient's account.
- Care Credit: 6 month interest-free and all interest bearing plans. If interested, please arrange this with our staff prior to the day of your surgical appointment. This will not be arranged on the day of surgery.
- We do not arrange any other types of payment plans.

Regarding Divorce: We will not become involved in disputes between divorced parents regarding financial responsibility for their child's medical/dental expenses or shared payment arrangements. The person who accompanies the child is responsible for the necessary payment. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

Failure of payment: A finance charge will be applied to all balances over 30 days old, including accounts with outstanding balances from insurance companies. The finance charge is 1.5% per month with an annual percentage rate of eighteen percent (18%). If it becomes necessary for our practice to use an outside means of collecting on the patient's account (such as a collection agency, legal or court fees), you agree to be responsible for all additional fees incurred by Germantown Oral & Facial Surgery Center to collect on the delinquent account.

Missed or Late appointments: We make every effort to schedule and treat patients as promptly as possible, and patients who do not keep their appointments prevent others from receiving care promptly. A **missed appointment** occurs when you fail to notify our staff least 2 business days in advance of the appointment. A **late arrival** means arriving more than 15 minutes late to your appointment. Late arrivals may be worked in as quickly as possible while respecting the other scheduled patients' appointments. **We reserve the right to charge a $50 fee for each missed consultation and a $150 fee for each missed surgery appointment**. Except in the case of emergent follow-up care after surgery, patients will not be rescheduled unless this fee has been paid in full. Patients who have 2 or more missed appointments within any given 12-month period or who have an excessive history of late arrivals, missed appointments, or a combination of the two will be subject to discharge from the practice.

Medicare/Medicaid: We do not participate with Medicare or Medicaid. We will not file these claims.

Insurance carriers require claims to be submitted in a timely manner. If you do not hear from your insurance carrier or us within two (2) months of treatment, please contact us. **You will be responsible for any fees that have not been paid by your insurance carrier within three (3) months of the date of service, regardless of the reason**. We will not become involved in disputes between you and your insurance carrier.

- **I certify that I have read and understand the financial policies, that my questions, if any, have been answered to my satisfaction, & that I agree to abide by these statements during the course of treatment.**
- **I understand my financial responsibility to pay all charges for rendered services not covered by insurance and not paid by the insurance carrier regardless of any estimates given prior to treatment and regardless of the reason.**
- **Should I fail to ensure that the insurance information provided to the staff of Germantown Oral & Facial Surgery Center is accurate and up-to-date at the time of treatment, I waive my right to insurance coverage and therefore I accept personal responsibility for the full payment of the services rendered.**
- **I will not hold the doctors, associates, or staff of Germantown Oral & Facial Surgery Center responsible for any errors or omissions in information or my failure to abide by the policies set forth above**.
- **I hereby authorize & request my insurance carrier(s) to pay the insurance benefit directly to Germantown Oral & Facial Surgery Center or Dr. Kenneth J. Wu, Dr. Mathew K. Woodward, or Dr. Zachary D. Saltman.**

Signature of patient/guarantor Printed Name Date

Witness (Germantown Oral & Facial Surgery Staff) Date

(This will be scanned into the patient's chart as part of the record, and this copy will be returned to the patient/guarantor)