UT★OMS Oral and Maxillofacial Surgeons

a part of UT★Dentists

Smith Tower
6550 Fannin St., Suite 2237
Houston, TX 77030
Ph: 713-790-4600
Fax: 713-793-1229

Appointment Date:_____ Time:_____ Doctor:_____

Dear New Patient:

Welcome to our practice and thank you for giving us the opportunity to evaluate and manage your oral surgical needs. For your convenience we are enclosing some forms and information to prepare you for your first visit. Please complete the Registration Form and Medical Questionnaire and read and sign the Financial Policy and HIPAA Compliance form.

In addition to those forms, you will need to bring your medical/dental insurance card(s). If you are a member of an HMO plan, a written referral/authorization is required and you are responsible for obtaining this. Contact your PCP (Primary Care Physician) and have them fax the referral to our office at 713-793-1229 prior to the appointment date. Please be aware that without the referral we cannot file a claim to your HMO plan. This means that you may be responsible for payment of services.

A recent panorex (xray), no older than 6 months, will be required for all TMJ evaluations and extraction consults, and may be helpful for other consults as well. If you have had a recent panorex, please have a copy forwarded to us prior to the appointment or bring it with you. If no panorex has been taken, indicate this to your PCP so they can include approval of the panorex on the referral/authorization.(Please see attached instructions on how to send us your xray.)

We have also included a map in your welcome packet. Parking is available in our building, the Smith Tower. The rate is determined by the amount of time you are parked in the garage. Valet parking is also available. We are unable to validate your parking so please be prepared for the additional expense.

Here is a quick review of all the things you will need to make your first visit go smoothly. We hope you find this helpful.

First Visit Checklist	
	Registration Form Completed
	Medical Questionnaire Completed
	Financial Policy Read and Signed
	HIPAA Compliance Form Read and Signed
	Medical/Dental Insurance Card(s)
	Referral/Authorization Faxed (For HMO Plan Members & Extraction Consults)
	Referral from General Dentist for Extraction Consult showing teeth to be extracted
	Copy of Panorex (If taken within last 6 months)
	Government Issued ID Card with Current Photograph (Driver's License, passport, of State of Texas ID)

Like most healthcare practices, it is imperative that you arrive on time for your appointment. If you need to reschedule, please give 24 hours' notice. If you have any other questions please do not hesitate to contact us at 713-790-4600. Thank you for this opportunity. We look forward to meeting you.

Sincerely,

Carmen A. Cabrera

Carmen A. Cabrera
Clinic Manager

UT Oral & Maxillofacial Surgery- Medical Questionnaire

Date:_____
Last Name:_____ First:_____ MI:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell/Page/Other:_____
SS#:_____ DOB:_____ Age:_____ Marital Status: _____

Emergency contact- Name:_____ Relationship:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell/Page/Other: _____

Referred By- Name: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Primary Care Physician-Name: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

What is the reason for your visit with us? _____

Do you have or have you had any of the following? Check if Yes

GENERAL
_____ Recent weight change
_____ Weakness
_____ Fatigue
_____ Fever
_____ Cancer
_____ HIV infection / AIDS
SKIN
_____ Rashes
HEAD
_____ Headache
_____ Head injury
EYES
_____ Vision problems
_____ Double vision
_____ Glaucoma
EARS
_____ Hearing problems
_____ Ringing in the ears
_____ Earaches
_____ Ear infections
NOSE AND SINUSES
_____ Stuffiness
_____ Discharge
_____ Hay fever
_____ Nose bleeds
_____ Sinus trouble
MOUTH and THROAT
_____ Bleeding gums
_____ Frequent sore throats
_____ Hoarseness
NECK
_____ Lumps in the neck
_____ "Swollen glands"
_____ Goiter

RESPIRATORY
_____ Cough
_____ Sputum
_____ Coughing blood
_____ Wheezing
_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
CARDIOVASVULAR
_____ Heart trouble
_____ High blood pressure
_____ Rheumatic fever
_____ Heart murmur
_____ Mitral valve prolapse
_____ Chest pain or discomfort
_____ Angina
_____ Heart attack
_____ Palpitations
_____ Pacemaker
_____ Difficulty breathing
_____ Swollen ankles
_____ Heart failure
_____ Heart surgery
_____ Stroke
_____ Thrombophlebitis
GASTROINTESTINAL
_____ Trouble swallowing
_____ Heartburn
_____ Nausea/vomiting
_____ Vomiting blood
_____ Diarrhea
_____ Abdominal pain
_____ Jaundice

_____ Liver trouble
_____ Hepatitis
URINARY
_____ Kidney problems/dialysis
_____ Difficulty urinating
_____ Urinary infections
_____ Stones
MUSCULOSKELETAL
_____ Muscle or joint pain
_____ Stiffness
_____ Arthritis
_____ Gout
_____ Joint implants
NEUROLOGIC
_____ Fainting
_____ Seizures/ epilepsy
_____ Weakness
_____ Paralysis
_____ Numbness
_____ Tingling
HEMATOLOGICAL
_____ Anemia
_____ Bleeding problems
_____ Blood disorders
ENDOCRINE
_____ Diabetes
_____ Thyroid disorders
_____ Other hormonal problems
_____ Steroids last 2 Yrs
PSYCHIATRIC
_____ Nervousness
_____ Tension
_____ Depression
_____ Anxiety

Is there anything you would like to discuss in private with the doctor?_____

PLEASE COMPLETE BACK

Have you had any diseases, medical problems, or hospitalizations in the last two years? Please list:

List all surgeries you have had in the past- Include dates:

List all medications you are taking now:

Are you allergic to dental anesthetics?
Are you allergic to any other medications?
Do you use alcohol or tobacco products?
Do you use recreational drugs?

Please list any other medical problems you have or have had in the past:

FOR WOMEN ONLY

Are you, or do you suspect you might be pregnant? ☐ YES ☐ NO
Surgery or anesthesia during early pregnancy can have serious consequences, including potential harm to the fetus.

Patient Photograph Release

I give permission to UT Oral & Maxillofacial Surgery and its authorized representatives to take and reproduce photographs in connection with my diagnosis, care and treatment, including surgical procedures, and authorize that such photographs may be part of the doctor's files or medical record. I also authorize the doctor to use and publish these photographs at his or her discretion for educational and research purposes, provided that I shall not be identified by name in any such publication use.

Patient's Signature Date

I have answered all the above to the best of my ability.

Patient's Signature Date

UT Oral & Maxillofacial Surgery- Insurance Registration

Date:_____

Patient's Last Name:_____ First:_____ MI:_____

Patient's SS#:_____ DOB:_____ Age:_____ Marital Status: _____

If Minor, Parent or Guardian's Name:_____ Relationship:_____

If patient 18 years or over and insured by parent: Is patient a student? YES ☐ NO ☐ If yes, circle one: FULL-TIME ☐ PART-TIME ☐

Name of School:_____ Have you provided proof of student status to insurance company? YES ☐ NO ☐

Please tell us about your insurance coverage- Check all that apply and complete fields:

1. MEDICAID OR MEDICARE

Medicaid/Medicare#:_____ Type (To be completed by office staff):_____

If you have Medicare Supplemental, please complete Section 3 and put supplemental insurance info in the Secondary Insurance fields.

2. WORKERS COMPENSATION

Name of Insurance Company:_____ Claim#:_____

Case Worker's Name:_____ Phone#:_____

Date of Injury:_____ Employer:_____

3. MEDICAL INSURANCE

PRIMARY: Name of Insurance Company:_____

Policy Holder's Name:_____ SSN:_____ DOB:_____

Policy Holder's Employer:_____ Relationship to Patient:_____

SECONDARY: Name of Insurance Company:_____

Policy Holder's Name:_____ SSN:_____ DOB:_____

Policy Holder's Employer:_____ Relationship to Patient:_____

4. DENTAL INSURANCE

PRIMARY: Name of Insurance Company:_____

Policy Holder's Name:_____ SSN:_____ DOB:_____

Policy Holder's Employer:_____ Relationship to Patient:_____

SECONDARY: Name of Insurance Company:_____

Policy Holder's Name:_____ SSN:_____ DOB:_____

Policy Holder's Employer:_____ Relationship to Patient:_____

I hereby assign insurance benefits to UT Oral & Maxillofacial Surgery (UTOMS). I authorize UTOMS to release any information necessary to secure the payment of benefits. I understand that if I have not furnished completely accurate insurance information before the service is performed, UTOMS may refuse to accept assignment or re-file the claim with the correct carrier. I understand and agree that UTOMS will quote the benefits information received from the carrier and will use that information to estimate my portion; however, I am responsible for all charges (unless enrolled in a federally funded program or HMO).

_____ _____

Patient or Parent/Guardian Signature Date

Revised 03/03

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Financial Policy

We are pleased that you have chosen the University of Texas Oral and Maxillofacial Surgery Associates for the evaluation and management of your surgical needs. We hope that your experience here will be exceptional.

We strive to communicate clearly and effectively with you in all aspects of your care. We have created this policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address those to the receptionist or office manager before you sign the acknowledgement.

1. Forms of Payment: Payment for services is expected the same day services are performed. For your convenience, we accept Visa, MasterCard and American Express, in addition to cash, checks, and money orders. You will be responsible for paying a $25 fee for returned checks.

2. Insurance Benefits: We will be happy to file your insurance claims as an added service to you. However, it is important that you understand that your insurance company does not share financial responsibility for your bill. Unless you are insured by a federal or state funded program you are responsible for all charges if your insurance company fails to pay.

3. Pre-Authorizations/ Pre-Certifications: You are responsible for obtaining authorizations from your PCP for office visits, when required by your insurance company. We will be happy to see you without the proper authorization but you will be required to pay for the visit. For surgeries or procedures to be performed by our doctors, we will attempt to get the service pre-authorized. If the insurance company denies the service we will notify you. If you have a question concerning your benefits you should direct those to your insurance company.

4. Patient Portion vs. Insurance Portion: Before a service or surgery is performed, we will attempt to estimate the portion of the service that your insurance company will not cover. We will notify you of that portion either orally or written and you will be expected to pay your estimated portion on or before the service date. For procedures to be performed in the operating room, your estimated portion will be due on or before the pre-operative visit. As mentioned above, the insurance portion is estimated and is never a guarantee of payment even after an authorization has been obtained (except for state and federal funded programs). Ultimately, your bill is your responsibility regardless of insurance benefits.

5. Denied or Unpaid Insurance Claims: We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit payment within 120 days of the service date, you will responsible for the balance, unless you are insured by an HMO plan. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on a service, and our attempts to appeal the denial fail, you are responsible for the balance. Unfortunately, this sometimes happens even after the service has been pre-authorized.

6. Financial Arrangements: In the event of financial hardship, optional payment arrangements may be discussed with the office staff before the planned date of the procedure or surgery. Since the doctor's main focus is on your health and treatment, they are unable to discuss fees or payment arrangements with you. If alternate arrangements are not requested and agreed upon before the date of the procedure, full payment of the patient's estimated portion will be due, as detailed in this policy.

7. Cancellation of Appointments: In fairness to other patients and the doctor, we require 24 hours notice if you must cancel an appointment. We reserve the right to charge a $25 fee for missed appointments without 24 hour notification.

8. Parking: Parking in the Smith Tower is the patient's responsibility and we cannot validate your parking ticket. The amount charged is determined by time spent in the garage, with a maximum charge of $11.00.

Thank you again for entrusting us with your care. If you have any questions about this policy or something not addressed in the policy, do not hesitate to ask a member of our office staff.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all dental, medical and/or surgical benefits to the doctors of UT Oral & Maxillofacial Surgery Associates and authorize the release of medical information to insurance companie(s), when requested or necessary. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original.

AGREEMENT WITH FINANCIAL POLICY

I have read and agree to the above financial policy. I understand that I am ultimately responsible for all fees for services provided to me.

_____

Patient's Name (Printed)

_____ _____

Patient or Responsible Party's Signature Date

_____

Printed Name of Signer, If Different from Patient

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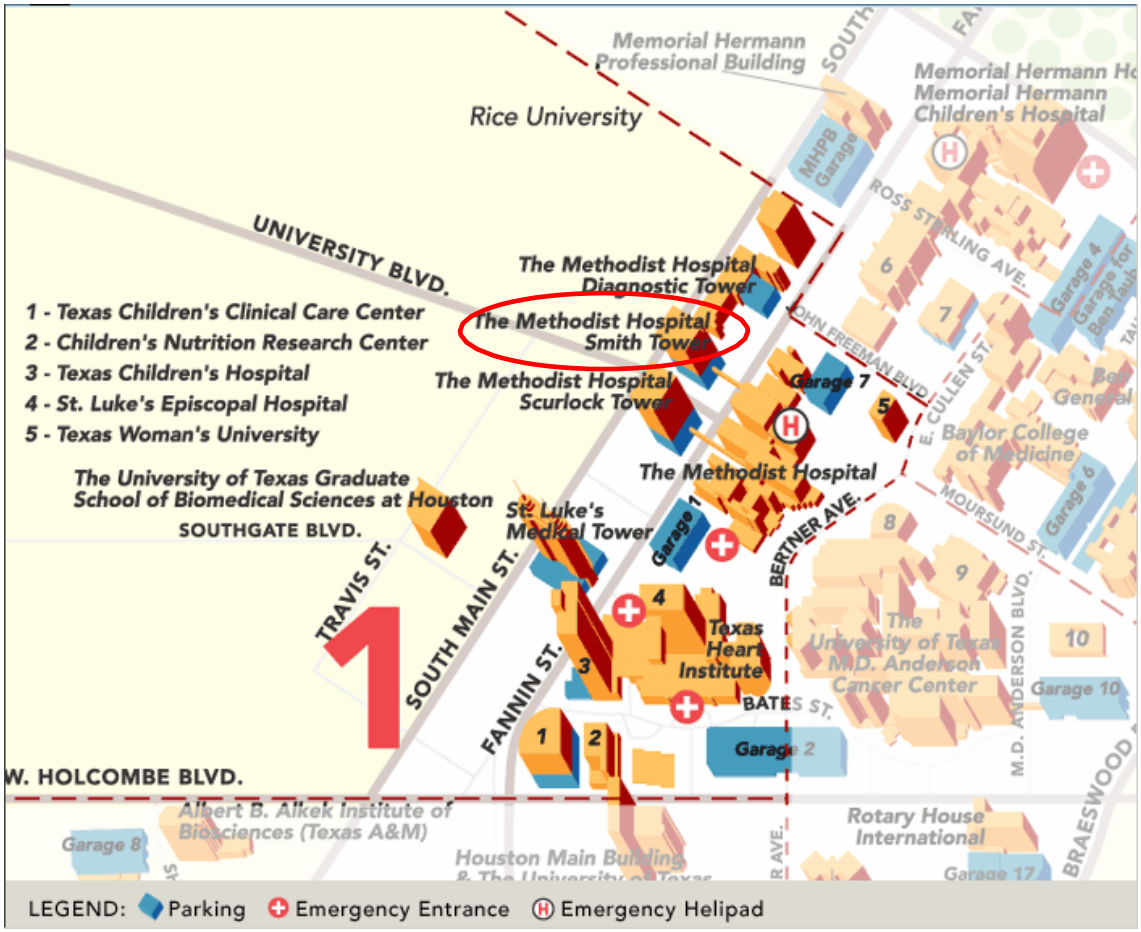
Please visit the website of Texas Medical Center at: http://www.tmcmaps.info/ for detailed direction, or see next page for brief maps to ourOffice.



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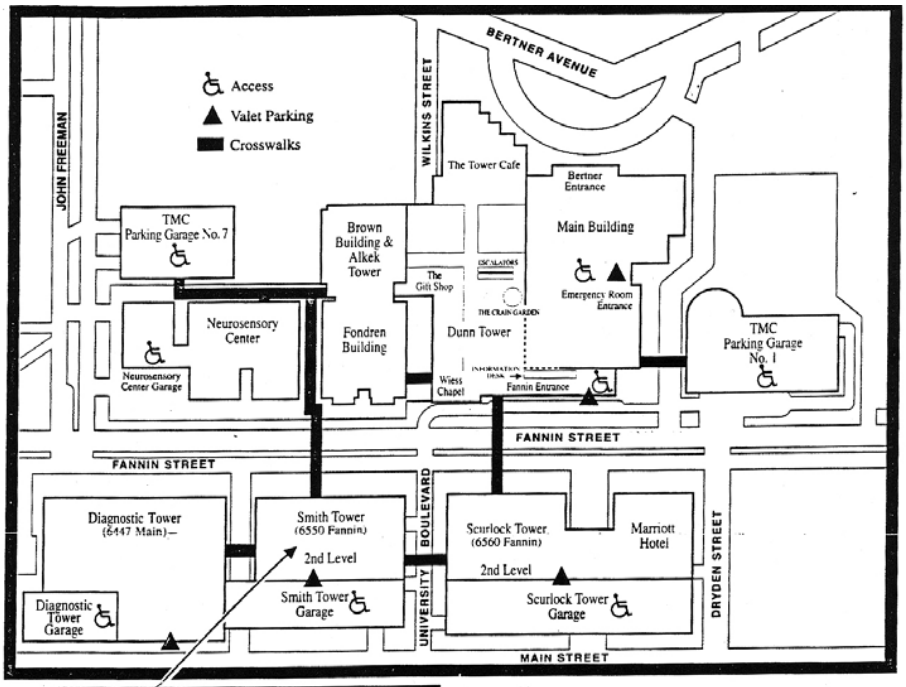
Smith Tower and Texas Medical Center Maps



We are located in the Smith Tower, Suite 2237.