EASTERN VIRGINIA
ORAL & MAXILLOFACIAL SURGERY

Trent P. Conelias, D.D.S., P.C.*
Geoffrey M. Schreiber, D.D.S.
*DIPLOMAT OF THE AMERICAN BOARD & ORAL MAXILLOFACIAL SURGERY

Email: hello@easternvirginiaoms.com
www.easternvirginiaoms.com

WELCOME!

EASTERN VIRGINIA ORAL AND MAXILLOFACIAL SURGERY IS PLEASED THAT YOU ARE SCHEDULED FOR AN APPOINTMENT WITH US FOR YOUR ORAL SURGERY CARE.

WE ARE ENCLOSING FORMS FOR YOU TO FILL OUT AND BRING WITH YOU THE DAY OF YOUR APPOINTMENT. THIS WILL DECREASE THE PAPERWORK THAT YOU WILL HAVE TO FILL OUT IN THE OFFICE. **PLEASE FILL THIS PACKET OUT IN ITS ENTIRETY. WE DO REQUIRE ALL OF THE INFORMATION IN THIS PACKET SO WE CAN BEST ASSIST YOU.**

PLEASE REMEMBER TO BRING THE FOLLOWING DOCUMENTS. **THESE ARE VERY IMPORTANT:**

1. BOTH YOUR DENTAL AND MEDICAL INSURANCE CARDS
2. A WRITTEN REFERRAL FROM YOUR GENERAL DENTIST OR OTHER DOCTOR
3. YOUR CO-PAYMENT, AS REVIEWED AT YOUR CONSULT
4. ANY X-RAYS YOUR DENTIST MIGHT HAVE TAKEN
5. A LIST OF YOUR CURRENT MEDICATIONS YOU ARE CURRENTLY TAKING

THANK YOU FOR CHOOSING OUR PRACTICE. WE LOOK FORWARD TO SEEING YOU AT YOUR APPOINTMENT.

TRENT P. CONELIAS, D.D.S., PC

P.S.

IF MINOR CHILDREN WILL BE ACCOMPANYING YOU, PLEASE BE SURE TO BRING ADEQUATE SUPERVISION.

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## PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MS. ☐ DR. _____
FIRST NAME M.I. LAST NAME NICKNAME

SEX ☐ MALE ☐ FEMALE BIRTHDATE _____ AGE _____ SOC SEC. # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME TEL. (____)_____ CELL (____)_____ EMAIL: _____

HAVE YOU BEEN A PATIENT OF OUR PRACTICE? ☐YES ☐NO DENTIST _____ _____
FIRST NAME LAST NAME

MEDICAL DOCTOR: _____ _____ REFERRED BY: _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

DRIVER'S LIC. # _____ EMPLOYER _____ BUS. TEL (____)_____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ HOME TEL. (____)_____
FIRST NAME LAST NAME

## PERSONAL INFORMATION

ARE YOU A STUDENT? ☐ YES ☐ NO SCHOOL NAME _____

NAME OF SPOUSE OR OTHER GUARANTOR _____ RELATION _____
FIRST NAME MI. LAST NAME

SOC. SEC # _____ BIRTHDATE _____ EMPLOYER _____

ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME TEL. (____)_____ WORK TEL. (____)_____ CELL #. (____)_____

## HEALTH HISTORY

TO OUR PATIENTS: ALTHOUGH DENTISTS PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS PART OF OUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE OR MEDICATIONS THAT YOU MAY BE TAKING COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE CARE THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL REMAIN CONFIDENTIAL.

REASON FOR TODAY'S VISIT _____

☐YES ☐NO ARE YOU IN GOOD HEALTH? HEIGHT _____ WEIGHT _____

☐YES ☐NO HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEATH IN THE PAST YEAR?

☐YES ☐NO ARE YOU UNDER THE CARE OF A PHYSICIAN? DATE OF LAST VISIT _____
IF SO, WHAT ARE YOU BEING TREATED FOR? _____

☐YES ☐NO HAVE YOU HAD ANY ILLNESS, OPERATION OR BEEN HOSPITALIZED?
IF SO, DESCRIBE _____

☐YES ☐NO DO YOU HAVE UNHEALED/RECURRENT INJURIES OR INFLAMED AREAS, GROWTHS OR SORE SPOTS IN OR AROUND YOUR MOUTH? IF SO, WHERE? _____

☐YES ☐NO DO YOU HAVE PROSTHETIC JOINT IMPLANT? IF SO, DESCRIBE WHERE _____

☐YES ☐NO HAVE YOU HAD A HEART VALVE REPLACEMENT OR VASCULAR GRAFT?

## HAVE YOU HAD OR CURRENTLY HAVE . . .

| | Yes | No | Notes |
|---|---|---|---|
| RHEUMATIC FEVER | | | |
| DAMAGED HEART VALVES/MITRAL VALVE PROLAPSE | | | |
| HEART MURMUR | | | |
| **HIGH BLOOD PRESSURE** | | | |
| LOW BLOOD PRESSURE | | | |
| **HEART ATTACK(S)** | | | |
| **IRREGULAR HEARTBEAT** | | | |
| **CARDIAC PACEMAKER** | | | |
| **HEART SURGERY** | | | |
| BRONCHITIS CHRONIC COUGH | | | |
| **ASTHMA** | | | |
| HAY FEVER/SINUS PROBLEMS | | | |
| SNORING/SLEEP APNEA | | | |
| DIFFICULT BREATHING/OTHER LUNG TROUBLE | | | |
| TUBERCULOSIS | | | |
| EMPHYSEMA | | | |
| DO YOU SMOKE | | | |
| DO YOU USE CHEWING TOBACCO | | | |
| BLOOD TRANSFUSSION | | | |
| **BLOOD DISORDER SUCH AS ANEMIA** | | | |
| BRUISE EASILY | | | |
| BLEEDINGTENDENCY/ ABNORMAL BLEED | | | |
| HEPATITIS, JAUNDICE OR LIVER DISEASE | | | |
| INFECTIOUS MONONUCLEOSIS | | | |
| GALLBLADDER TROUBLE | | | |
| FAINTING SPELLS | | | |
| CONVULSIONS/EPILEPSY | | | |

**PLEASE LIST ANY MEDICATIONS YOU ARE TAKING IN THIS BOX**

## HAVE YOU HAD OR CURRENTLY HAVE . . .

| | Yes | No | Notes |
|---|---|---|---|
| STROKE | | | |
| THYROID TROUBLE | | | |
| **DIABETES** | | | |
| LOW BLOOD SUGAR | | | |
| KIDNEY TROUBLE | | | |
| ARE YOU ON DIALYSIS | | | |
| SWOLLEN ANKLES, ARTHRITIS OR JOINT DISEASE | | | |
| STOMACH ULCERS | | | |
| CONTAGIOUS DISEASES | | | |
| SEXUALLY TRANSMITTED DISEASES | | | |
| ARE YOU IMMUNOSUPRESSED? POSSIBLY FROM TRANSPLANT SURGERY, ETC. | | | |
| DELAY IN HEALING | | | |
| TUMOR OR GROWTH | | | |
| RADIATION THERAPY/ CHEMOTHERAPY | | | |
| CHRONIC FATIGUE/ NIGHT SWEATS | | | |
| ARE YOU ON A DIET | | | |
| **A HISTORY OF DRUG ABUSE** | | | |
| A HISTORY OF ALCOHOL ABUSE | | | |
| CONTACT LENSES | | | |
| EYE DISEASE/GLAUCOMA | | | |
| MENTAL HEALTH PROBLEMS | | | |
| A REMOVABLE DENTAL APPLIANCE | | | |
| PAIN AND CLICKING OF JAWS WHEN EATING | | | |
| MALIGNANT HYPERTHERMIA | | | |
| **IF YOU ARE HAVING A SURGERY TODAY, HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE LAST 8 HOURS** | | | |
| WHO IS DRIVING YOU HOME | | | |

## MEDICATION
## ARE YOU NOW TAKING OR HAVE YOU TAKEN . . .

| | Yes | No | Notes |
|---|---|---|---|
| ANY KIND OF MEDICATION, DRUG, PILLS | | | |
| **BLOOD THINNERS (COUMADIN, PLAVIX, ASPIRIN, VITAMIN E, GINKO BILOBA)** | | | |
| HAVE YOU EVER TAKEN DIET PILLS | | | |
| ANY NATURAL PRODUCT, HERBAL SUPPLEMENT OR HOMEOPATHIC REMEDY | | | |
| ANY BONE DENSITY MEDICATIONS/ BIPHOSPHATES (AREDIA, ZOMETA, FOSAMAX, ACOTONEL) | | | |
| TRANQUILIZERS, SLEEPING PILLS, ANTI-DEPRESSANTS AND/OR NARCOTICS ON A REGULAR BASIS? IF SO, PLEASE LIST | | | |

## ALLERGIES
## ARE YOU ALLERGIC TO OR HAD A REACTION TO

| | Yes | No | Notes |
|---|---|---|---|
| LOCAL ANESTHETIC (NUMBING MEDICATION) | | | |
| PENICILLIN | | | |
| OTHER ANTIBIOTICS | | | |
| SULFA DRUGS | | | |
| SODIUM PENOTHAL VALIUM, OR OTHER TRANQUILIZERS | | | |
| ASPIRIN | | | |
| CODENE OR OTHER NARCOTICS | | | |
| OTHER MEDICATIONS | | | |
| **LATEX** | | | |
| SOY | | | |
| EGGS/YOLK | | | |
| SULFITES | | | |
| PLEASE LIST ANY ALLERGIES OTHER THAN DRUG ALLERGIES | | | |

## IS THIS VISIT RELATED TO AN ACCIDENT? ☐ YES ☐ NO

AUTOMOBILE WORK RELATED

OTHER _____ DATE OF INJURY _____

INSURANCE COMPANY HANDLING THIS CLAIM

_____

CLAIM NUMBER _____

NAME OF ATTORNEY/ADJUSTER _____

TELEPHONE NUMBER (_____)_____

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD KNOW ABOUT?

☐ YES ☐ NO IF SO, PLEASE DESCRIBE

IS THERE A FAMILY HISTORY OF:

CANCER ☐ YES ☐ NO DIABETES ☐ YES ☐ NO

HEART DISEASE ☐ YES ☐ NO

ANESTHETIC PROBLEMS ☐ YES ☐ NO

## IN CASE OF EMERGENCY

NAME _____

HOME TEL. (_____)_____

BUS. TEL. (_____)_____

## FOR WOMEN ONLY

IS THERE A POSSIBILITY OF PREGNANCY ☐ YES ☐ NO

EXPECTED DELIVERY DATE _____

HOW MANY WEEKS/MONTHS IN PREGNANCY? _____

ARE YOU NURSING? ☐ YES ☐ NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

DATE OF LAST MENSTRUAL CYCLE _____

WOMEN NOTE: ANTIBIOTICS SUCH AS PENICILLIN MAY ALTER THE EFFECTIVENESS OF BIRTH CONTROL PILLS. CONSULT YOUR PHYSICIAN/GYNECOLOGIST FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST OR ANY OTHER MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN COMPLETING OF THIS FORM.

PATIENT SIGNATURE _____ REVIEWED BY _____
(PARENT OF GUARDIAN IF MINOR)

## NOTICE OF PRIVACY POLICIES

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU, AS PROVIDED IN OUR NOTICE. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY REQUEST A REVISED COPY. I HAVE BEEN PROVIDED A COPY OF DR. CONELIAS' NOTICE OF PRIVACY PRACTICES. I HAVE HAD AN OPPORTUNITY TO READ THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I MAY ASK QUESTIONS TO DR. CONELIAS' STAFF IF I DO NOT UNDERSTAND ANY INFORMATION CONTAINED IN THE NOTICE OF PRIVACY PRACTICE.

_____
PATIENT SIGNATURE DATE

_____
AUTHORIZED REPRESENTATIVE OF PATIENT RELATIONSHIP TO PATIENT

## AUTHORIZATION

I AUTHORIZE MY DENTIST AND HIS/HER DESIGNATED STAFF TO PERFORM DENTAL EXAMINATION FOR THE PURPOSE OF DIAGNOSIS AND TREATMENT PLANNING. FURTHERMORE, I AUTHORIZE THE TAKING OF ALL X-RAYS REQUIRED AS A NECESSARY PART OF THIS EXAMINATION. IN ADDITION, IF MEDICALLY NECESSARY, I AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND TREATMENT.

DATE: _____ PATIENT SIGNATURE _____ WITNESS _____

I HEREBY ACKNOWLEDGE THAT A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES HAS BEEN MADE AVAILABLE TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE REGARDING THIS NOTICE.

PATIENT SIGNATURE _____ DATE _____

# FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing us as your dental provider. We are committed to providing you with the highest quality of dental care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

■ ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

■ WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. No in house financing is provided. If you prefer to make monthly payments, we offer financing with prior credit approval through CareCredit. Please ask for an application.

In respect to those services for which insurance will be filed by this office, it is the policy of Trent P. Conelias, D.D.S., P.C. that said filing is done solely as a courtesy to the patient. The financial responsibility for services rendered rests solely with the patient/guarantor. The agreement of the insurance company to pay for medical and/or dental care is a contract between the patient and the insurance company. Verification of your insurance coverage is not a guarantee of benefits. Your insurance carrier will determine benefits at the time a claim is submitted and acknowledged. It is the patient/guarantor's responsibility to pay for any non-covered services, deductibles, co-payments or any other balance not paid by the insurance company. I agree and understand that failure to provide the correct insurance information at the time of service means that I will be responsible for full payment of my account, and that I must wait for all insurance reimbursement(s) including any contracted insurance companies that Trent P. Conelias participates with. I further understand that once payment is received, the office of Trent P. Conelias will make any required contracted insurance adjustments and I will be reimbursed accordingly. I agree and understand that I am responsible for obtaining all referral information required from my primary care physician, dentist and insurance company (if applicable) so that the office of Trent P. Conelias can file my medical and/or dental insurance (if applicable). I further understand that failure to do so will result in my being responsible for all fees related to services rendered.

I assign all benefits to Trent P. Conelias, D.D.S., P.C. and I understand and agree that in the unlikely event this account is referred to an attorney for collection then the undersigned person (s) promise and agree to pay all collection costs including attorney fees of 33 1/3% of the principal amount due and owing when turned over for collection and do further agree to pay interest at a rate of 1 ½% per month (18% per Annum) on the unpaid balance from the date the services were last rendered. I authorize photocopies of this form to be as valid as the original. In the event this matter is turned over for collection, I hereby expressly give permission for my current employer (s) to provide verification of my said employment to this office, or their attorney.

I understand and agree that it is my responsibility to come in for all scheduled appointments and that I am required to give this office a 48 hour (business hours) notice to avoid any cancelation or broken appointment fee. I understand that in the event I do not provide this office with proper cancellation notice, I will be charged and agree to pay as follows: $150 for surgery and $75.00 for any other service. I understand and agree to pay the fee of $45.00 for any return check, and if this occurs, I understand that I will be required to pay by cash or credit card for all future payments.

We do our best to provide our patients with accurate costs pertaining to their treatment. However, all treatment plans given are an estimate. At times, unanticipated procedures may arise during a procedure that cannot be avoided to complete treatment. Although this is not common, if this does occur, any additional cost will be due in full from you as the patient/guarantor.

I have read, understand, and agree to this Financial Responsibility Agreement.

_____ _____/_____/_____

Signature of Patient/Guarantor Date

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## MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

POLICY HOLDER'S DATE OF BIRTH: _____

GROUP #: _____ POLICY #: _____

## DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

NAME OF POLICY HOLDER: _____

POLICY HOLDER'S SOCIAL SECURITY #: _____

POLICY HOLDER'S DATE OF BIRTH: _____

GROUP #: _____ POLICY #: _____

WITHOUT THE ABOVE INFORMATION WE ARE UNABLE TO PROPERLY FILE YOUR INSURANCE. IF AN INSURANCE PAYMENT IS NOT RECEIVED IN 90 DAYS, THE OUTSTANDING BILL BECOMES YOUR RESPONSIBILITY.

PATIENT'S SIGNATURE: _____ DATE: _____

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please read the following statement carefully

**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, uses and disclosures we may make of your protected health information, and of other important matters concerning your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Practice Manager/ HIPPA Compliance Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____/_____/_____

**Signature** **Date**

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Legal Representative's Name: _____

Relationship to Patient: _____

## AUTHORIZTION TO RELEASE MEDICAL/DENTAL INFORMATION

**I do authorize** Eastern Virginia Oral & Maxillofacial Surgery, Trent P. Conelias, D.D.S., P.C. to release any and all information concerning my care to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____/_____/_____

**Patient Signature** **Date**

## HIPAA NOTICE OF PRIVACY PRACTICES

**This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below.

**Typical uses and disclosures of health information**

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information per their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that my become involved in the process of mailing statements and/or collection unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information to whom we are required to do so by law. (Court or administrative orders, subpoena, discovery requests or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.