EASTERN VIRGINIA
ORAL & MAXILLOFACIAL SURGERY

www.easternvirginiaoms.com

Trent P. Conelias, D.D.S., P.C.
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6033 Providence Road
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Phone: 424-2672
Fax: 366-0482

Thank you for choosing Eastern Virginia Oral & Maxillofacial Surgery for your oral care. We look forward to seeing you!

What will you need to have with you for your first appointment:

- The enclosed forms completed and signed
- Your dental and medical insurance cards (front and back)
- A photo ID
- A referral from your general dentist or the provider who referred you to our office

You can also fax to the number listed above or email all of the above information to **hello@easternvirginiaoms.com** so that we can have everything ready when you come in!

If you are scheduled to have surgery with sedation be sure to call our office the day before to get pre-operative instructions.

- Basic instructions are:
  - Wear loose clothing
  - No jewelry
  - No nail color or acrylic on your index fingers
  - Nothing to eat or drink for at least 8 hours prior
  - You must have an escort who will remain on premises during your procedure and will drive you home

Please call or text us to confirm your appointment.

If you must cancel or reschedule, we require at least 48 hours notice (unless it is for an emergency) to avoid a cancellation fee. This will allow us time to refill the slot.

Please feel free to call with any questions or concerns.

Doctors and Staff of Eastern Virginia Oral & Maxillofacial Surgery

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Dr. Trent P. Conelias, DDS Dr.
Geoffrey M. Schreiber, DDS

PATIENT INFORMATION

Name: _____
Last Name, First Name, Middle initial

Address: _____
Street, City, State, Zip

Date of Birth: _____ Sex: _____ SSN: _____

Telephone Number: _____ ◯Cell ◯Home ◯Work
Telephone Number: _____ ◯Cell ◯Home ◯Work

Email Address: _____ May we ◯Text ◯Email

Primary Care doctor: _____ Dentist: _____

Emergency Contact: _____
Name, Relationship, Telephone number

Dental Insurance: *We must have a copy of the front and back of your insurance card to file claims*

Company: _____ Subscriber: _____
ID #: _____ Date of birth: _____
Group #: _____

Medical Insurance: *We must have a copy of the front and back of your insurance card to file claims*

Company: _____ Subscriber: _____
ID #: _____ Date of birth: _____
Group #: _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each consultation visit or prior to surgery. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.
This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I have been given the opportunity to review the notice of Privacy Practices for Eastern Virginia Oral & Maxillofacial Surgery. I understand the terms stated herein are to remain in effect throughout my treatment with EVOMS.

Patient/Legal Guardian/Guarantor: _____ Date: _____

Witness: _____ 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/HIPAA 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 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 of your notice of privacy practices. I understand that, by signing this 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: _____

AUTHORIZATION TO RELEASE MEDICAL/DENTAL INFORMATION

I do authorize Trent P. Conelias, DDS, PC /Eastern Virginia Oral & Maxillofacial Surgery to release any and all information concerning my care to the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Patient/Legal guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Eastern Virginia Oral & Maxillofacial Surgery as your dental provider.

We are committed to providing you with the highest quality 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 prior to any treatment.

- All copays in deductibles are due at the time of service.
- We accept cash, checks, visa, MasterCard, American Express, and Discover.
- We do not offer in-house financing. If you prefer to make monthly payments, we offer financing with prior credit approval, through CareCredit. We are happy to provide the information.
- All treatment plan financial quotes are an **ESTIMATE**. Final patient financial responsibility cannot be determined until AFTER the claim has been submitted and processed by the carrier.

In respect to those services for which insurance will be filed by this office:

- 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 upon submission and processing of your claim.
- It is the patient/guarantor responsibility to pay for any non-covered services, deductibles, co-payments or any other balance not paid for by the insurance company.
- Failure to provide the correct insurance information at the time of service means that the patient/guarantor will be responsible for the full payment of the account.

My signature below represents my understanding and agreement to the items above and the following:

- I assign all benefits to be paid to EVOMS.
- I hereby authorize the release of information necessary to process any submitted insurance claims.
- In the event of further collection action being taken: ○ I will be fully responsible for collection costs up to 33 1/3 % of the principal amount due. ○ I will be responsible for interest on the outstanding amount at the rate of 1 ½ % monthly on the unpaid balance.
    - ○ I give my current employer permission to verify my employment to this office or their attorney.
- Photocopies of this form are as valid as the original.

Signature: _____ Date: _____

APPOINTMENT CONFIRMATION, CANCELLATION AND NO-SHOW POLICY

Attending all appointments as scheduled is crucial to successful treatment.

CONFIRMATIONS ARE REQUIRED: EVOMS uses an automated confirmation system. Patients will receive text/email notifications of upcoming appointments and schedule changes. Timely response to these notifications is required. Patient are encouraged to contact the offices with any questions or concerns regarding the schedule.

- If an appointment is not confirmed by **24 hours before the scheduled time**, the appointment will be cancelled and a fee charged. The fee must be paid before another appointment will be scheduled.
  - $150.00 for a non-confirmed surgical appointment
  - $50.00 for a non-confirmed consultation appointment

LATE CANCELLATIONS: If you must cancel your appointment, **we require 48-hour notice**. You must speak to one of our office staff. Text and email messages are not accepted for cancellation.

- If an appointment is not cancelled with at least 48-hours verbal notice to the office staff a Late Cancellation fee will be charged. The fee must be paid before another appointment will be scheduled.
  - $150.00 for a late cancel surgical appointment
  - $50.00 for a late cancel consultation appointment

NO SHOW APPOINTMENTS: Failure to keep a scheduled appointment without any notice will result in a fee of $150.00 regardless of the appointment type. Another appointment will not be scheduled until the fee is paid.

Repeated cancellations may result in discharge from the practice.

My signature below represents my full understanding and acceptance of the APPOINTMENT CONFIRMATION, CANCELLATION AND NO-SHOW POLICY.

Signature: _____ Date: _____

Virginia Code § 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

"Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure."

I hereby give my consent to be tested, at the expense of the practice, should any provider of or person employed by Eastern Virginia Oral & Maxillofacial Surgery come into contact with my bodily fluids in a manner that may transmit HIV, or hepatitis B or C viruses. I will be informed of the details of the incident and be given the opportunity to have any questions answered.

Signature: _____ Date: _____

Witness: _____ Date: _____

HEALTH HISTORY/SUMMARY 11.3022

Patient Name: _____ DOB: _____

Sex: _____ Dentist: _____ Last Visit: _____

Reason for today's visit: _____

YES	NO	Height: Weight:			
		Are you in good health?			
		Have there been any changes in your general health over the past year?			
		Are you under the care of a physician? Date of last visit: _____ What are you being treated for? _____			
		Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? If so, where:			
		Do you have a prosthetic joint implant? If so, where:			
		Have you had a heart valve replacement or vascular graft? If so, describe:			
YES	**NO**	**CONDITION**	**YES**	**NO**	**CONDITION**
		Damaged heart valves/Mitral valve prolapse			Are you immunosuppressed possibly from transplant surgery
		Heart Murmur			Diabetes
		High Blood Pressure			Low Blood Sugar
		Low Blood Pressure			Kidney Trouble
		Heart Attack(s)			Are you on Dialysis
		Irregular Heartbeat			Swollen ankles, Arthritis, or Joint Disease
		Cardiac Pacemaker			Stomach Ulcers
		Heart Surgery			Contagious Diseases
		Bronchitis, Chronic Cough			Sexually Transmitted Disease
		Asthma			Thyroid Trouble
		Hay Fever/Sinus Problems			Delay in Healing
		Snoring / Sleep Apnea			Tumor or Growth
		Difficult Breathing/ Other lung Trouble			Radiation Therapy/Chemotherapy
		Tuberculosis			Chronic Fatigue / Night Sweats
		Emphysema			Are you on a diet
		Do you smoke			Do you have a history of drug abuse
		Do you use chewing tobacco			Do you have a history of alcohol abuse
		Blood transfusion			Contact lenses
		Blood disorder such as anemia			Eye Disease/Glaucoma
		Bruise easily			Mental Health Problems
		Bleeding Tendency/Abnormal Bleeding			A removable dental appliance
		Hepatitis, Jaundice, or Liver Disease			Pain and clicking of jaws when eating
		Infectious mononucleosis			Malignant Hyperthermia
		Gallbladder Trouble			Anything to eat or drink in the last 8 hours
		Fainting Spells			Convulsions/Epilepsy
		Developmental Delays / Autism			Osteoporosis
		HIV / AIDS Positive			
		Are there any conditions concerning your health that the doctor should know about?			
Who is driving you home					

CURRENT MEDICATIONS *(Please list medications you are currently taking)*

ALLERGIES	**YES**	**NO**	**CURRENT OR PAST MEDICATIONS**	**YES**	**NO**
Local Anesthesia (Numbing medication)			Any kind of medication, drug, pills		
Penicillin			Blood thinners		
Other antibiotics			Diet Pills		
Sodium Pentothal, Valium, or other tranquilizers			Natural Product, Herbal Supplement, or Homeopathic Remedy		
Sulfa Drugs			Bone Density Medications		
Codeine or other Narcotics			Tranquilizers, Sleeping Pills, Antidepressants, Narcotics on a regular basis		
Aspirin			Marijuana, any form		
Latex			**FAMILY HISTORY**	**YES**	**NO**
Soy			Cancer		
Eggs/Yolks			Diabetes		
Sulfites			Heart Disease		
Any other allergies			Anesthetic Problems		

WOMEN ONLY	**YES**	**NO**	**ACCIDENT**	**YES**	**NO**
Is there a possibility of pregnancy			Automobile accident Date:		
Expected delivery date			Work Accident Date:		
How many weeks /months			Insurance for claim		
Are you nursing			Claim #		
Are you taking birth control pills			Adjustor Name		
Date of last menstrual cycle			Phone number		
Additional methods of birth control			**Automobile or work-related accidents may have different reimbursement requirements. Speak with our Treatment Coordinator to ensure correct benefits.**		
Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.					

PAST SURGICAL HISTORY *(Please list past surgeries and approximate dates)*

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 may satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I have made in completing this form.

I authorize my dentist and his designated staff to perform a 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.

Patient/Guardian Signature: _____ Date: _____