ALEX RABINOVICH DDS, MD
Board Certified Oral & Maxillofacial Surgeon

New Patient Information Sheet

Please print clearly. Please complete all information

PATIENT INFORMATION

Full Name: First: Last: Preferred Name:

Date of Birth: Sex: Male / Female Marital Status: S M W D

Street Address: City: State: Zip:

Phone #: **Social Security** #:

Email:

Referred by: (How did you hear about us?) Dr. _____ / INTERNET / INSURANCE / FRIEND

Treating Dentist: Group: Phone:

Emergency Contact: Name: Phone Number:

INSURANCE INFORMATION

PIMARY	SECONDARY (OR MEDICAL)
Insurance Co:	Insurance Co:
Insurance Address:	Insurance Address:
Subscriber's Name: **DOB:**	**Subscriber's Name:** **DOB:**
ID (or Subscriber's SS):	**ID:**
Group #	Group #

Notice of Privacy Practices for Protected Health Information – (Please see attached HIPPA Form)

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

I hereby assign, transfer, and set over to Alex Rabinovich MD, DDS, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date:

HEALTH HISTORY

Patient Name:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____
5. Yes No Are you allergic to any medications?_____
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	41.	Yes	No	HIV/AIDS?
30.	Yes	No	Heart attack, heart defects?	42.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	43.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	44.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	45.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	46.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	47.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	48.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	49.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	50.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	51.	Yes	No	Diabetes?
40.	Yes	No	Problems with your TMJ (Jaw Joints)				

IV. DO YOU HAVE OR HAVE YOU HAD:

52.	Yes	No	Psychiatric care?	58.	Yes	No	Hospitalization?
53.	Yes	No	Radiation treatments?	59.	Yes	No	Blood transfusions?
54.	Yes	No	Chemotherapy?	60.	Yes	No	Surgeries?
55.	Yes	No	Prosthetic heart valve?	61.	Yes	No	Pacemaker?
56.	Yes	No	Artificial joint?	62.	Yes	No	Contact lenses?
57.	Yes	No	Treatment with bisphosphonates?				

V. ARE YOU TAKING:

63.	Yes	No	Recreational drugs?	65.	Yes	No	Tobacco in any form?
64.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	66.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

67.	Yes	No	Are you or could you be pregnant or nursing?	68.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

69. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

Doctor's signature:_____ Date:_____

Office Financial Policy

All payment is due in full before procedure is performed.

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, credit cards, debit cards and cashier's checks. Personal checks are accepted only as payment for services scheduled more than 10 business days in advance. **There is a $50 returned check fee**.

FOR PATIENTS UNDERGOING PROCEDURES COVERED BY INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance if proper insurance information is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

SURGERY FEES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Your insurance carrier may require prior authorization.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. To assist our patients, we offer financing through 3rd party financial institutions. Please ask our patient coordinator for details.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at reasonable costs and proper time management is crucial; **we require a 48 hour notice when canceling or rescheduling an appointment. If an appointment is scheduled for longer than 3 hours and needs to be cancelled or rescheduled, we require notification of 5 business days in advance.** We charge a fee for missed appointments without a proper notice equal to 10% of the total cost of treatment but not less than $100. A deposit equal to 10% of your out-of pocket fee is required at the time of scheduling.

For orthognathic surgery, a $2,500, non-refundable fee is collected prior to digital surgical planning, usually several weeks prior to your procedure. This fee applies even if the surgery is not performed but digital surgical planning has been completed.

The practice reserves the right to dismiss patients with excessive cancelled appointments.

I have read and understand the office Financial Policy

Patient Signature _____ Date: _____

We accept all major credit cards.

CareCredit®