THE DENTOFACIAL COSMETIC SURGERY INSTITUTE

PATIENT INFORMATION & HEALTH HISTORY

Patient's Name Date of Birth Height Weight Date

Answer all Questions by Circling YES (Y) or No (N)

ALL RESPONSES ARE KEPT CONFIDENTIAL

1. Are you in good health?.....Y N
2. Has there been any changes in your General health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for A particular problem?.....Y N
5. Have you **ever** had any serious illness, Operations or hospitalizations? If so, describe.....Y N

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease.....Y N
   - B. Congenital Heart Disease?.....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?.....Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness Of Breath, Chest Pain, Severe Coughing)?.....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Osteoporosis?.....Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
   - P. Radiation (X-ray) treatment of Cancer?.....Y N
   - Q. Clicking or popping of jaw joint, pain near ear Difficulty opening mouth, grind or clench teeth?.....Y N
   - R. Sinus or Nasal problems?.....Y N
   - S. Any disease, drug or transplant operation That has depressed your immune system?.....Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)?.....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?....Y N
   - D. High Blood Pressure medications?.....Y N
   - E. Steroids (Cortisone, Prednisone, etc).....Y N
   - F. Tranquilizers?.....Y N
   - G. Insulin or Oral Anti-Diabetic drugs?.....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?....Y N

I. Are you taking or **have you ever taken Bisphosphonates for** osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa?.....Y N

J. Have you ever been advised **not** to take a medication?.....Y N

K. Please list any and all medication taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

_____.

_____.

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc)?.....Y N
   - B. Penicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers?.....Y N
   - F. Latex or Rubber products?.....Y N
   - G. Metal of any kind?.....Y N
   - H. Chemicals or jewelry (rash or sensitivity)?.....Y N
   - I. Food products?.....Y N
   - J. Other allergies or reactions? Please list:.....Y N

_____.

_____.

9. Do you smoke or chew Tobacco?.....Y N
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide for you?.....Y N
11. Have you had any serious problems associated with any previous dental treatment?.....Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?...Y N
14. Do you wish to talk to the doctor privately about anything?.....Y N
15. Have you ever had a bone density scan?.....Y N
16. **FOR WOMEN ONLY:**
    - A. Are you pregnant or is there any chance you might be pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives,** it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date:_____ **Signature of Person Completing Health History:** _____ **Doctor's Initials:** _____

PATIENT INFORMATION & HEALTH HISTORY

Chief Dental Complaint: _____.

_____.

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ **PATIENT'S SIGNATURE:** _____

FOR COMPLETION BY THE DOCTOR:

Comments on patient interview concerning medical history: _____.

_____.

_____.

Significant findings from questions or oral interview: _____.

_____.

_____.

Dental Management Considerations: _____.

_____.

_____.

Date: _____ Dentist's Signature: _____

PATIENT INFORMATION & HEALTH HISTORY

SINCE OUR PROFESSION IS BASED ON AN APPOINTMENT SCHEDULE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS, UNLESS YOUR APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE, A CHARGE OF $30 WILL BE APPLIED TO YOUR ACCOUNT.

PATIENT INFORMATION RECORD (PLEASE PRINT)

Name _____ Age: _____ Marital Status: _____

Date of Birth: _____ [ ] Male [ ] Female Social Security # _____

Address: _____ City _____ State _____ Zip Code_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Referral? _____

How did you hear of our office? _____

IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION:

As a courtesy we will file dental insurance for our patients. We will accept assignment of insurance benefits for certain procedures. However, we do require co-pays to be paid at the time of service. Any remaining balance, or non-covered expense, **IS THE RESPONSIBILITY OF THE INSURED/PATIENT.**

Name of Insured: _____ Relationship to Pt: _____

Home Phone: _____ Insured's DOB: _____ SS#_____

Address: _____ City _____ State_____ Zip_____

Employer/Retired From: _____ Work Phone _____

Insurance Company: _____ Group #_____

Insured ID #_____ Does this Ins Cover: [ ] Medical [ ]Dental [ ] Both

Responsible Party: [ ] Self [ ]Spouse [ ]Parent [ ] Other ***WE DO NOT ACCEPT DISCOVER OR AMERICAN EXPRESS***

Guarantor Name: _____ Phone Number_____

Address: _____City_____State_____ Zip_____

PATIENT SIGNATURE: X_____ **DATE**: _____

RESPONSIBLE PARTY SIGNATURE: X_____ DATE:_____

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www.DentofacialInstitute.com
Michael M. Hashemian, D.M.D., M.D.

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- Invisalign Teen
- Dental Extraction
- TMJ Management
- Facial Cosmetic Surgery
- Face & Neck Lift
- Chin & Cheek Implants
- Eyelid Surgery
- Eyebrow Lift
- Botox / Dysport
- Facial Fillers
- Face & Neck Liposuction
- Rhinoplasty, Nose Job
- Correction of Facial Deformities
- Hair Restoration
- Laser Resurfacing for Wrinkles and Scars
- Snoring, Sleep Apnea Treatment / Surgery

PRE-OPERATIVE INSTRUCTIONS FOR PATIENTS HAVING SEDATION ANESTHESIA

___ 1. **NOTHING TO EAT OR DRINK (including water)** 6 hours prior to appointment except for scheduled medication.

___ 2. No illegal street drugs and no alcohol at least 48 hours prior to surgery.

___ 3. Have a responsible adult accompany you to the surgery appointment, stay at the office while you are in surgery and drive you home. They should be available for you at home the day of surgery.

___ 4. Wear loose and comfortable clothing, short sleeves, and flat shoes on the day of surgery. No nail polish, and no pantyhose.

___ 5. Inform the doctor of any changes in your medical history or medications.

___ 6. You will be given oral and written post op instructions and prescriptions on the day of surgery. Be prepared to have prescriptions filled at the pharmacy on the day of or prior to surgery. We offer some prescriptions to be filled in office.

___ 7. Have ice packs, plenty of liquids, of soft cold foods available.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

THE PATIENTS' DRIVER IS NOT ALLOWED TO LEAVE THE PREMISES WHILE THE PATIENT IS GETTING SURGERY!!

IF THE DRIVER ***MUST*** LEAVE, THEY HAVE TO RETURN WITHIN 10-15 MINUTES AND GIVE THE FRONT DESK A PHONE NUMBER TO CONTACT. IF THE PATIENT IS READY TO GO AND THE DRIVER IS NOT ON-SITE, WE WILL PUT THE PATIENT IN A TAXI CAB AND IT WILL BE THE PATIENTS RESPONSIBILITY FOR THE FARE.

_____ _____

Patients Signature Date

ANY MISSED APPOINTMENTS AND/OR CANCELLATIONS WITHIN A 24 HOUR TIMEFRAME WILL IMPOSE A ***$75.00*** CHARGE TO YOUR ACCOUNT

_____ _____

Patients Signature Date

THE DENTOFACIAL COSMETIC SURGERY INSTITUTE

HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company),
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

DATE: _____

PRINT PATIENT NAME: _____

SIGNATURE OF PATIENT: _____

RELEASE OF INFORMATION TO SPOUSE: _____

CHILD: _____

OTHER: _____

MESSAGES: PLEASE CALL ME AT—[ ] WORK [ ] HOME [ ] CELL PHONE: _____

SPRING HILL: 32 Seven Hill Drive ◦ Spring Hill, FL 34609 ◦ (352)688-4556 ◦ 1-800-726-4536 ◦ Fax: (352) 688-6238
LECANTO: 591 N. Lecanto Hwy ◦ Lecanto, FL 34461 ◦ (352) 527-8000 ◦ Fax: (352)527-8087
LAND O'LAKES: 2651 Narnia Way, Suite 101 ◦ Land O' Lakes, FL 34638 ◦ (813) 922-1818 ◦ Fax: (813) 949-1411

THE DENTOFACIAL & COSMETIC SURGERY INSTITUTE

FINANCIAL POLICY

Thank you for choosing The Dentofacial Institute for your oral surgery needs. We are committed to your being successful. In order to achieve these goals we need your assistance. Please take a moment to read and understand our financial polity. Please understand that payment of your bill is considered part of your treatment and the following is a statement of our Financial Policy that we require all patients to read and sign prior to any treatment.

Payment for service is due in full at the time they are rendered. We do not bill for services. We do not accept post dated checks. We accept cash, personal checks, Debit Cards, Master Card and Visa.

Regarding Insurance: If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. PLEASE NOTE THAT WE **DO NOT** DO VERBAL AUTHORIZATIONS WITH INSURANCE COMPANIES. We will call your insurance company to get a breakdown of benefits. Whatever your insurance does not cover, you are responsible for in full the day services are rendered. If your dental insurance requires claims to be submitted to medical insurance first, you would pay in full and we will give you the information to file for your reimbursement. **WE DO NOT FILE FOR MEDICAL INSURANCE**. In the event we do accept assignment of benefits, we require that you be ***preauthorized*** and pay your portion of the claim prior to your surgical procedure. If your insurance company has not paid your account, in full, within forty-five days, you will automatically be billed for the balance which you will be required to pay and then you will need to contact your insurance company for reimbursement. Remember, your insurance policy is a contract between you and your insurance company and not the doctor and the insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered service and not considered reasonable and necessary under your insurance plan.

MEDICARE: We do not participate with Medicare, which means members pay in full the day services are rendered.

HMO RECIPIENTS: We do not accept or participate with Medicaid Humana, AvMed, Well Care (medical) or any HMO insurances, **nor do we file for reimbursement with any of these insurances**. Please note that because we are not a provider with any of these types of insurance's that your insurance will deny the claim if you try to submit for reimbursement. Since we are not a provider of these types of insurance, any type of supplemental insurance will not cover the procedure either.

NON-INSURANCE PATIENTS: We do not offer a payment plan in our office. However, we do offer some outside financing companies that you can use for your treatment fees. Payment is due in full the day services are rendered.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR).

LATE FEES: Any balance over thirty (30) days will be subject to an interest fee of either 12% or 18% additional to the balance depending on the amount of time it takes to collect the total balance.

If you have any questions regarding our charges or payment policy, please do not hesitate to ask. In cases of divorced or separated parents, the parent bringing the child will be deemed responsible for payment.

I have read and understand The Dentofacial Institute's financial policy as stated above.

_____ _____

Signature of Patient or Parent/Guardian **Date**

SPRING HILL: 32 Seven Hill Drive ◦ Spring Hill, FL 34609 ◦ (352)688-4556 ◦ 1-800-726-4536 ◦ Fax: (352) 688-6238
LECANTO: 591 N. Lecanto Hwy ◦ Lecanto, FL 34461 ◦ (352) 527-8000 ◦ Fax: (352)527-8087
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- Wisdom Teeth
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- TMJ Management
- Facial Cosmetic Surgery
- Face & Neck Lift
- Chin & Cheek Implants
- Eyelid Surgery
- Eyebrow Lift
- Botox / Dysport
- Facial Fillers
- Face & Neck Liposuction
- Facial Mole Removal
- Correction of Facial Deformities
- Hair Restoration
- Laser Resurfacing for Wrinkles and Scars
- Snoring, Sleep Apnea Treatment / Surgery

IF YOU ARE HAVING SURGERY WITH IV SEDATION OR GENERAL ANESTHESIA

We ask that your driver DO NOT leave our office once you go back for surgery. In case your driver leaves our office or doesn't show up at all, we will allow you to stay in our recovery room for only 15 minutes. If after recovery from anesthesia your driver does not return within that time frame, we will have no choice but to call a taxi service to drive you home.

Anesthesia time is defined as the period during which the patient is being monitored. This period starts as soon as the patient is under anesthesia monitoring until the end if the anesthesia service. This includes recovering the patient from anesthesia under our supervision. The anesthesia time could be for administration of inhalational anesthesia, intravenous medication, intravenous fluid or monitoring the vital signs. The length of the anesthesia time is often longer then the surgery time depending on how soon the patient emerges from anesthesia.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

32 Seven Hills Drive, Spring Hill, Florida 34609 (352) 688-4556
591 North Lecanto Highway, Lecanto Florida 34461 (352) 527-8000
2651 Narnia Way, Suite 101, Land O' Lakes, Florida 34638 (813) 922-1818
2431 Estancia Boulevard, Suite D, Clearwater, Florida 33761 (727) 796-1716

INSURANCE AGREEMENT

Please understand that your out-of-pocket cost on the day of treatment is an estimation only. Your insurance company advised us that they cannot give us an exact cost of coverage and/or payment until the actual claim is submitted and they have processed the claim. Because our office does not participate with every insurance company, we cannot go off of every schedule allowance. Due to this fact there may be a difference between our submitted cost and their allowed cost.

Please understand that you will be financially responsible for any amount over your yearly maximum, any deductibles, or once services have been rendered any service that your insurance company denies payment on. Remember that your insurance policy is a contract between you and your insurance company and not the doctor and the insurance company. Please understand that if this occurs the balance must be paid in full within forth-five (45) or the account will be turned over to The Dentofaciai Institute's attorney for collections. If the account is assigned to an attorney for collection and/or suit, you will be responsible for all attorney's fees and cost of collections.

Signature:_____ Date: _____

MEDIA RELEASE FORM

I, _____, grant permission to the Dentofacial & Cosmetic Surgery Institute, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❑- Videos ❑- Email Blasts ❑- Recruiting Brochures ❑- Newsletters ❑- Magazines
❑- General Publications ❑- Website and/or Affiliates ❑- Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 18 years of age)