



PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

GENDER: \_\_\_\_\_ PREFERRED PRONOUNS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHYSICAL ADDRESS (if different): \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_

PREFERRED CONTACT METHOD: PHONE \_\_\_ TEXT \_\_\_ EMAIL \_\_\_ REFERRING PROVIDER: \_\_\_\_\_

RELATIONSHIP STATUS:

SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ PARTNERED \_\_\_\_\_ SEPARATED \_\_\_\_\_ DIVORCED \_\_\_\_\_ WIDOWED \_\_\_\_\_

**PRIMARY DENTAL INSURANCE:** INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ POLICY ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE:** INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ POLICY ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**MEDICAL INSURANCE:** INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ SUBSCRIBER DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_ POLICY ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**GUARANTOR INFORMATION (IF PT IS A MINOR):**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHYSICAL ADDRESS (if different): \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

I understand that I am ultimately responsible for all costs of dental treatment and professional services rendered for the patient named above regardless of insurance status. If I DO NOT PAY the entire balance when due, a service charge will be added to the account for the current billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum of \$5.00), which is an annual percentage rate of 18% applied to the last month's balance. In the case of default payment, I promise to pay any legal fees on the balance due, together with any collections costs and reasonable attorney fees incurred to effect collection of this account.

I FURTHER UNDERSTAND THAT ANY REMAINING BALANCE IS DUE IN FULL 60 (SIXTY) DAYS FROM THE DATE OF SURGERY REGARDLESS OF INSURANCE STATUS. Uninsured portion is due at the time of services/surgery.

\_\_\_\_\_  
Signature of patient, parent, or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, or guardian: Relationship

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Today's Date \_\_\_\_\_

**An accurate and complete health history will assist in coordinating your care.  
Please speak with Dr. Griffitts or staff if there are any questions about this form.**

**DENTAL HISTORY**

Please describe why you are in the office today: \_\_\_\_\_

Are you having any dental discomfort at this time?

Please describe: \_\_\_\_\_

Have you had any adverse effects from dental treatment?

Please describe: \_\_\_\_\_

Do you have or have you ever had any of the following:

**YES NO**

**YES NO**

Bleeding, sore gums

Shifting in bite

Unpleasant taste/bad breath

Change in bite

Swelling/lumps in mouth

Clicking/popping jaw

Orthodontic treatment (braces)

Difficulty opening or closing jaw

Clenching/grinding

**MEDICAL HISTORY**

Have there been any changes in your general health in the past year?

Please describe: \_\_\_\_\_

Are you now under a doctor's care for a medical condition?

Physician Name & Phone#: \_\_\_\_\_

Please describe: \_\_\_\_\_

Please list the date of your last physical exam: \_\_\_\_\_

Have you ever been hospitalized or had a serious illness?

Please describe: \_\_\_\_\_

Please list any past surgeries, including surgery type, date of surgery, reason for surgery and any complications:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**MEDICAL HISTORY (continued)**

Do you have, or have ever had:

	YES	NO		YES	NO
Congenital heart disease			Kidney failure, requiring dialysis		
Heart attack			Liver disease or jaundice		
Heart murmur, rheumatic or scarlet fever			Hepatitis A, B or C		
Coronary Artery Disease			Vertigo		
Chest pain			Anemia or other blood disorder		
High or low blood pressure			Bleeding tendency or bruise easily		
Stroke			Thyroid disease		
Irregular heartbeat			Stomach ulcers or colitis		
Heart surgery			Glaucoma		
Pacemaker or implantable defibrillator			Arthritis or gout		
Cardiac stent			Osteoporosis or osteopenia		
Artificial heart valve, repaired heart defect (PFO)			Sleep apnea		
Orthopedic or soft tissue implant (joint replacement, breast implant)			Snoring		
Pneumonia			Epilepsy		
Bronchitis			Neurologic disorders		
Tuberculosis			STI/STD/HPV		
COPD			HIV/AIDS		
Emphysema			Hepatitis: Type _____		
Severe coughing			Diabetes: Type _____		
Breathing problems (Asthma, stuffy nose, sinus or nasal issues)			Cancer: Type _____		
Kidney Disease					

**FAMILY MEDICAL HISTORY:** Do you have a family history history of any of the following conditions?

	YES	NO		YES	NO
Diabetes			Relationship _____	Heart Disease	
Lung Disease			Relationship _____	Bleeding problems	
Cancer			Relationship _____	Relationship _____	

Please describe: \_\_\_\_\_

**MEDICATIONS:** Are you currently prescribed or taking any of the following:

	YES	NO		YES	NO
Antibiotics			Prescription pain medication		
Anticoagulants or blood thinners			Aspirin, Motrin, Aleve, Ibuprofen or other anti-inflammatories		
Heart medications			Insulin or oral anti-diabetic drugs		
Steroids (cortisone or prednisone)			Blood pressure medications		
Antianxiety agents, antidepressants, psychiatric medications			Bisphosphonates or bone strengthening medications		
Cancer or chemotherapy drugs			Any other medications or supplements		

**MEDICATIONS (continued):** Please list the specific medications that you are currently taking, including any medications noted above. Please include all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication	Dose	Medication	Dose

Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**MEDICAL HISTORY (continued)**

**ALLERGIES** – Are you allergic to or have you had an adverse reaction to:

YES	NO	YES	NO
		Codeine or other pain control medications	
Latex		Aspirin, Ibuprofen (Motrin), or Naproxen (Aleve)	
Food or food products		Penicillin or other antibiotics	
Sedatives or barbiturates		Any other allergies	
Any other medications			
If yes, please describe _____			

**ANESTHESIA HISTORY**

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation?

If yes, please describe: \_\_\_\_\_

**FEMALE PATIENTS** - Are you:

YES	NO
Pregnant	
Any chance you may be pregnant	
Taking birth control?	
Breastfeeding?	

**SOCIAL HISTORY**

Do you currently use any tobacco products? (e.g. cigarettes, cigars, chewing tobacco, e-cigarettes/vaping)  
Please specify type, frequency and duration of use: \_\_\_\_\_

Do you currently consume alcohol?  
Please specify type, frequency and duration of use: \_\_\_\_\_

Do you currently use marijuana or cannabis products?  
Please specify type, frequency and duration of use: \_\_\_\_\_

Do you currently use any recreational drugs? (e.g. cocaine, ecstasy, methamphetamines, LSD, etc.)  
Please specify type, frequency and duration of use: \_\_\_\_\_

Have you ever sought professional care or been hospitalized for substance abuse, emotional disorders or alcoholism?  
Please describe: \_\_\_\_\_

**I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.**

\_\_\_\_\_  
Signature of patient, parent, or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, or guardian: Relationship

Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Please select Yes (Y) for the following conditions that apply to your health. Per category, if you are not having any difficulties, please select "None".

**GENERAL**

Fever  
 Frequent fatigue  
 Frequent weakness  
 Recent weight gain  
 Recent weight loss  
 None

**CARDIOVASCULAR**

Chest Pain  
 Palpitation  
 Shortness of breath  
 Swelling of feet, ankles or hands  
 None

**RESPIRATORY**

Persistent cough  
 Shortness of breath  
 Wheezing  
 None

**ENDOCRINE**

Dry skin  
 Excessive thirst/urination  
 Glandular/hormonal issue  
 Heat/Cold intolerance  
 None

**ENT**

Bad breath or bad taste  
 Bleeding gums  
 Chronic rhinitis  
 Chronic sinus issues  
 Dry mouth  
 Earaches or drainage  
 Hearing loss or ringing  
 Mouth sores  
 Nose bleeds  
 Painful swallowing  
 Sore throat or voice change  
 Swollen glands in neck  
 None

**YES NO****EYES**

Blurred vision  
 Double vision  
 Dryness  
 Flashing or spots in vision  
 Loss of vision  
 Pain  
 Redness  
 Scratchy feeling  
 Wear contact lenses  
 Wear glasses  
 Wear reading glasses  
 None

**GASTROINTESTINAL**

Abdominal pain  
 Change in/Painful bowel movements  
 Nausea/Vomiting  
 Rectal bleeding/Blood in stool  
 None

**GENITOURINARY**

Blood in Urine  
 Burning or painful urination  
 Female - irregular periods  
 Frequent urination  
 Incontinence or dribbling  
 Kidney stones  
 Male - testicular pain  
 Strain when urinating  
 None

**HEMATOLOGIC**

Anemia  
 Bleeding/bruising tendency  
 Enlarged glands  
 Past transfusion  
 Phlebitis  
 Slow healing  
 None

**YES NO****INTEGUMENTARY**

Breast lump  
 Breast pain  
 Change in hair or nails  
 Change in skin color  
 Rash or itching  
 Varicose veins  
 None

**MUSCULOSKELETAL**

Back Pain  
 Cold extremities  
 Difficult in walking  
 Joint pain  
 Joint stiffness or swelling  
 Muscle pain or cramps  
 Weakness of muscles or joints  
 None

**NEUROLOGICAL**

Convulsions or seizures  
 Frequent or recurring headaches  
 Head injury  
 Light-headed or dizzy  
 Numbness or tingling sensations  
 Paralysis  
 Tremors  
 None

**PSYCHIATRIC**

Depression  
 Insomnia  
 Memory loss or confusion  
 Nervousness  
 None

**YES NO**



Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Thank you for choosing Griffitts Facial & Oral Surgery. Our primary mission is to deliver the best and most comprehensive Facial and Oral Surgery care. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options. Our office accepts: Cash/Check, Visa®, MasterCard®, CareCredit Credit Card®<sup>1</sup>, and Sunbit® payment plans.

Please note:

1. Upon check-in, payment for services is due in full on the day of your scheduled service.
2. For patients with In-Network Insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement of your treatment. If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
3. For patients with Out-of-Network Insurance, we will assist you in seeking reimbursement for your treatment by managing the the initial billing for Out-of-Network Insurance carriers.<sup>2</sup>
4. Patients who receive surgery will be scheduled for post-operative visits to promote your recovery process and lower risk of complications.
  - a. Minor Surgery post-operative visits and possible imaging are to be scheduled within a 14-day window from date of surgery. These services are included in the cost of your surgery.
    - i. All charges for visits performed in relation to a Minor Surgery scheduled after the 14-day window are billable.
    - ii. During this 14-day period, any visit not related to the surgery will be considered a billable charge.
  - b. Major Surgery post-operative visits and possible imaging are to be scheduled within a 90-day window from date of surgery. These services are included in the cost of your surgery.
    - i. All visits performed in relation to a Major Surgery scheduled after the 90-day window are billable.
    - ii. During this 90-day period, any visit not related to the surgery will be considered a billable charge.
5. A fee of \$50 is charged for missed or canceled appointments occurring without 48 hours' notice.
6. There is a \$30 charge for returned checks.

If you have any questions, please contact the Billing Department (208) 667-0824. We are here to help you get the Facial and Oral Surgery care you need.

\_\_\_\_\_  
Signature of patient, parent, or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, or guardian: Relationship

<sup>1</sup>CareCredit is a credit card offered by Synchrony Bank and is NOT an in-house credit program offered by Griffitts Facial & Oral Surgery or any other healthcare provider. You may apply for the CareCredit healthcare credit card and if approved, use it at Griffitts Facial & Oral Surgery's office. However, the CareCredit credit card agreement is between you and Synchrony Bank. Subject to credit approval.

<sup>2</sup>Payment in full is required at the time of service. We will submit your Out of Network claim to your insurance company on your behalf. Your insurance company will reimburse/pay you directly should you be owed a refund.



HIPAA<sup>1</sup> AUTHORIZATION FORM

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Patient or guardian authorizes and directs any physician, other health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau or other health care clearinghouse and covered entities<sup>2</sup> that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services (collectively, the "Providers"), to release and disclose the Protected Health Information<sup>3</sup> described herein to the following party(ies) as my agent, to be treated as I would with respect to my rights regarding the use and disclosure of my protected health information.

Please list those individuals whom you give your permission to speak to Griffitts Facial & Oral Surgery in your behalf. **If the individual is not listed below, our office will not be able to communicate with them regarding your treatment or billing in our office.**

Name/Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Name/Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

Name/Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

A. Limitations on Authorization

Extent of Authorization

I authorize the release of all of my protected health information, including: history/physical exam results, progress notes, physician's orders, patient allergies, consultation reports, discharge summaries, pathology reports, operative reports, emergency room record, laboratory reports, x-rays, imaging reports, abstracts or summaries and the contents of medical records.

Period of Health Care Covered by the Authorization

This authorization of the release of my protected information covers all past, present and future protected health information.

Electronic Disclosure

I further acknowledge that any protected health information disclosed pursuant to this authorization may be re-disclosed electronically and consent to the protected health information being disclosed electronically.

<sup>1</sup> The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards and procedures that covered entities must follow when disclosing a patient's protected health information.

<sup>2</sup> Covered entities are defined by HIPAA as health plans, health care clearinghouses and health care providers who conduct certain financial and administrative transactions electronically. These entities are bound by the privacy standards of HIPAA even if they contract with others to perform some of their essential functions.

<sup>3</sup> Under HIPAA, protected health information is individually identifiable information that is created, collected, or transmitted by a HIPAA-covered entity in relation to payment for healthcare services. Protected health information includes, but is not limited to, diagnoses, treatment information, medical test results, prescription information, birth dates, gender, ethnicity, contact and emergency contact information.



Patient's Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**B. Effective Time Period**

This authorization will be in effect until I expressly revoke authorization.

**C. Patient Rights and Acknowledgments**

- i) This release does not affect my ability to obtain treatment, payment, or eligibility for benefits.
- ii) I recognize that I have the right to inspect or copy the protected information held by covered entities.
- iii) I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent a provider has acted in reliance on it.
- iv) I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I can request and obtain a copy of the HIPAA Privacy Notice at any time. The date this form is signed is the effective date of this authorization.

\_\_\_\_\_  
Signature of patient, parent, or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient, parent, or guardian: Relationship

**We're happy to bill all insurances on your behalf, ensuring you receive the benefits you deserve.**

#### **OUT OF NETWORK INSURANCES:**

Our clinic offers claim submission as part of our commitment to your care.

- **WHAT WE DO FOR YOU:** We will take care of submitting your Out of Network claim to your insurance company on your behalf, ensuring that all required information is accurately provided while maximizing your benefits available under your policy.
- **WHAT THIS MEANS:** Your insurance company will reimburse/pay you directly should you be owed a refund.

We know that this first step in handling insurance claims can be daunting. By managing this initial submission for you, our goal is to help you get the process started smoothly, allowing you to focus on your health and recovery.

#### **IN NETWORK INSURANCES:**

Our clinic offers comprehensive billing support as part of our commitment to your care.

- **WHAT WE DO FOR YOU:** We will take care of submitting your In Network claim to your insurance company, ensuring that all required information is accurately provided while maximizing your benefits available under your policy.
  - We will actively follow up with your insurance provider to monitor the status of your claim.
  - We will work with you to provide any additional necessary details your insurance company requires.
- **WHAT THIS MEANS:** Your insurance company will pay our office directly. Should you be owed any refunds after your insurance has paid, our office will issue the refund check to you.

#### **MINOR SURGERIES:**

- Patients will be scheduled for a post-operative visit within a 14-day window from the date of surgery.
- This post-operative visit is at no charge and is included in the cost of the surgery when performed within the 14-day window from the date of surgery.
- Possible imaging performed within the 14-day window from the date of surgery is included in the cost of the surgery.
- During this period any visit or imaging not related to the surgery will be considered a billable charge.

#### **MAJOR SURGERIES:**

- Patients will be scheduled for post-operative visits within a 90-day window from the date of surgery.
- Including any imaging, these visits are at no charge and are included in the cost of your surgery.
- During this period any visit or imaging not related to the surgery will be considered a billable charge.
- New or existing services or treatment outside of the 14- or 90-day post-operative period is considered a billable charge.

Payment for all services is due in full at the time of check-in.

For questions, please contact the billing department at 208-667-0824.