ORTA ORAL SURGERY

813.238.0411 ■ Fax 813.238.5341
801 W. Dr. Martin Luther King Jr. Blvd., Tampa, FL 33603
www.OrtaOralSurgery.com

Chart Number _____

Date _____

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name _____ M.I. _____ Last Name _____
☐ Male ☐ Female Birthdate _____ Age _____ Social Security # _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone _____ Cell _____ E-mail _____
Driver's Lic.# _____ Nearest relative not living with you _____ Phone _____
Employer _____ Bus. Phone _____ Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card
Referred by _____ Dentist Name _____
Orthodontist Name _____ Medical Dr. Name _____
Have you ever been a patient of our practice? ☐ Yes ☐ No Has a family member ever been a patient of our practice? ☐ Yes ☐ No
In case of emergency contact _____ Phone _____ Relation _____

RESPONSIBLE PARTY

☐ Self (If self, skip this part) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____
Name _____ Birthdate _____ Age _____ Social Security # _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone _____ Cell _____ E-mail _____
Driver's Lic.# _____ Employer _____ Bus. Phone _____

GUARANTOR INFORMATION (If different from above)

Name _____ Relation _____ Birthdate _____ Social Security # _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone _____ Employer _____ Bus. Phone _____

INSURANCE INFORMATION

Dental Insurance

Primary: ☐ Insurance ☐ PPO ☐ HMO (Check one option)
Plan Name _____ Phone _____
Address _____ City _____ State _____ Zip Code _____
Employer _____
Union/Local _____ Group # _____ Plan # _____
Insured Party Name _____ Insured's SS # _____ Birthdate _____

Dental Insurance

Secondary: ☐ Insurance ☐ PPO ☐ HMO (Check one option)
Plan Name _____ Phone _____
Address _____ City _____ State _____ Zip Code _____
Employer _____
Union/Local _____ Group # _____ Plan # _____
Insured Party Name _____ Insured's SS # _____ Birthdate _____

Medical Insurance

Primary: ☐ Insurance ☐ PPO ☐ HMO (Check one option)
Plan Name _____ Phone _____
Address _____ City _____ State _____ Zip Code _____
Employer _____
Union/Local _____ Group # _____ Plan # _____
Insured Party Name _____ Insured's SS # _____ Birthdate _____

Medical Insurance

Secondary: ☐ Insurance ☐ PPO ☐ HMO (Check one option)
Plan Name _____ Phone _____
Address _____ City _____ State _____ Zip Code _____
Employer _____
Union/Local _____ Group # _____ Plan # _____
Insured Party Name _____ Insured's SS # _____ Birthdate _____

HEALTH HISTORY

To Our Patients

Although oral surgeons treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit _____

Height _____ Weight _____ Are you in good health? . . . . . ☐ YES ☐ NO

Have there been any changes in your general health in the past year? . . . . . ☐ YES ☐ NO

If YES please list: _____

Are you under the care of a physician? If so, date of last visit: _____ . . . . . ☐ YES ☐ NO

If YES, for what are you being treated? _____

Have you had any illness, operation, or been hospitalized in the past five years? . . . . . ☐ YES ☐ NO

If YES, describe: _____

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? . . . . . ☐ YES ☐ NO

If YES, describe where: _____

Do you have a prosthetic joint/implant? If so, describe where _____ . . . . . ☐ YES ☐ NO

Have you had a heart valve replacement or vascular graft? . . . . . ☐ YES ☐ NO

Have you or a family member had any unusual or serious reactions to general anesthesia? . . . . . ☐ YES ☐ NO

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? . . . . . ☐ YES ☐ NO

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?

	YES	NO	NOTES
Aids/HIV	☐	☐	
Anemia	☐	☐	
Anesthetic Problems	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding Tendency	☐	☐	
Blood Transfusion	☐	☐	
Bronchitis, Chronic Cough	☐	☐	
Bruise Easily	☐	☐	
Cancer	☐	☐	
Cardiac Pacemaker	☐	☐	
Chemotherapy or Radiation	☐	☐	
Chronic Fatigue/Night Sweats	☐	☐	
Contact Lenses	☐	☐	
Contagious Disease	☐	☐	
Convulsions/Epilepsy	☐	☐	
Delay in Healing	☐	☐	
Diabetes	☐	☐	
Dialysis	☐	☐	
Diet	☐	☐	
Difficulty Breathing/Lung problems	☐	☐	
Emphysema	☐	☐	
Epilepsy	☐	☐	
Eye Disease/Glaucoma	☐	☐	
Fainting Spells	☐	☐	
Gallbladder Trouble	☐	☐	
Hay Fever/Sinus Problems	☐	☐	
Heart Attack/Chest Pain/Angina	☐	☐	
Heart Disease	☐	☐	
Heart Murmur/Artificial Valves	☐	☐	
Heart Surgery	☐	☐	

	YES	NO	NOTES
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
History of Drug/Alcohol Abuse	☐	☐	
Infection	☐	☐	
Infectious Mononucleosis	☐	☐	
Irregular Heart Beat	☐	☐	
Jaundice, Hepatitis, Liver Disease	☐	☐	
Kidney Trouble	☐	☐	
Low Blood Pressure	☐	☐	
Low Blood Sugar	☐	☐	
Malignant Hyperthermia	☐	☐	
Mitral Valve Prolapse	☐	☐	
Osteoporosis/Osteopenia	☐	☐	
Osteonecrosis	☐	☐	
Psychiatric Disease	☐	☐	
Problems with Immune System	☐	☐	
Prosthetic Knee/Hip etc.	☐	☐	
Removable Dental Appliance	☐	☐	
Rheumatic Fever	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Smoker/Chewing Tobacco	☐	☐	
Sores in Mouth	☐	☐	
Snoring/Sleep Apnea	☐	☐	
Stomach Ulcers/Acid Reflux	☐	☐	
Stroke	☐	☐	
Swollen Ankles	☐	☐	
Thyroid Trouble	☐	☐	
TMJ-Pain & Clicking of Jaws	☐	☐	
Tuberculosis	☐	☐	
Tumor or Growth	☐	☐	

WOMEN ONLY

	YES	NO	NOTES
Possible Pregnancy	☐	☐	
Expected due date			

	YES	NO	NOTES
Nursing	☐	☐	
Birth control pills	☐	☐	

Note to Women
Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

ALLERGY INFORMATION

	YES	NO	NOTES
Local Anesthetic	☐	☐	
Penicillin	☐	☐	
Other Antibiotics	☐	☐	
Sulfa Drugs	☐	☐	
Sodium Pentothal, Valium or other Tranquilizers	☐	☐	
Aspirin	☐	☐	
Amoxicillin	☐	☐	
Codeine or other Narcotics	☐	☐	

	YES	NO	NOTES
Other Medications (Please list)	☐	☐	
Latex Allergy	☐	☐	
Soy/Eggs/Yolk	☐	☐	
Sulfites	☐	☐	
Any known allergies (please list)	☐	☐	

MEDICATION INFORMATION

	YES	NO	NOTES
Anticoagulant/Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)	☐	☐	
Have you every taken Diet Pills	☐	☐	
Natural or herbal supplement or homeopathic remedy	☐	☐	

	YES	NO	NOTES
Bone density or bisphosphonates (Fosamax, Boniva, Actonel, IV-Zometa, Aredia or Reclast in the past 12 years)	☐	☐	
Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis (please list)	☐	☐	

List all medications, drugs or pills you are currently taking

Medication	Dosage	Frequency

Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthesia problems

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? . . . . . ☐ YES ☐ NO
Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? . . . . . ☐ YES ☐ NO
If YES, describe: _____

Do you wish to speak to the doctor privately about anything? . . . . . ☐ YES ☐ NO

Is this visit related to an accident? . . . . . ☐ YES ☐ NO
If yes, what type of accident? ☐ Automobile ☐ Work related ☐ Other _____
Date of injury _____ Insurance company handling claim _____
Claim number _____ Name of attorney/adjustor _____
Phone _____

I certify that I have read and I 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 surgeon, or any other member of his staff, responsible for errors or omissions that I have made in the completion of this form.

Patient's Signature (Parent or Legal Guardian if minor) **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. 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, attorneys fees, and court costs.

_____ _____ _____

Patient's Signature (Parent or Guardian if minor) **Reviewed by** **Date**

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.

_____ _____

Patient's Signature (Parent or Guardian if minor) **Date**

AUTHORIZATION

I authorize my surgeon and his designated staff, to perform an oral and maxillofacial 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 to my other doctors and/or insurance carriers.

_____ _____

Patient's Signature (Parent or Guardian if minor) **Witness**

_____ _____

Doctor's Signature **Date**

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's Signature (Parent or Guardian if minor) **Date**

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PATIENT FINANCIAL RESPONSIBILITY POLICY & AGREEMENT

Name _____ Date _____
Last First

Payment Due at Time of Service
I understand that as a condition of being accepted as a patient by the Practice, the Practice requires payment in full at the time services are rendered by cash, check, credit card or by pre–arranged third– party financing, and I agree that I am personally responsible for all charges incurred. I understand I will receive an itemized estimate prior to service, and have the responsibility to ask any questions I may have regarding such estimate.

Insurance or Third Party Financing
I understand that my insurance policy or other third –party financing arrangement is a contract between myself and the insurer or financing company, and that regardless of the extent to which such contract provides coverage for the services I receive, I am personally responsible for all charges. I further understand that practice staff may provide me with assistance in locating available third–party financing companies and/or provide me with an itemized bill necessary for filing for reimbursement with my insurance company, but that such assistance in no way guarantees availability of financing or that my insurance will provide payment. I remain responsible for any amounts not paid by insurance, including co–payments, deductibles, and non– covered charges.

Missed Appointment Charge
In consideration of the time of the professionals who will provide my care, I understand I must cancel any appointment I have made but cannot attend at least 24 hours in advance. I further understand and agree that failure to cancel an appointment (other than bona fide emergency) pursuant to this policy may incur a charge equal to the scheduled service amount for such missed appointment, at the sole discretion of the practice.

Surgical Deposits
I understand that, in consideration of the time and efforts provided on my behalf by the practice in order to schedule a surgical procedure, the practice will require a deposit in the amount of fifty percent (50%) of the total estimated charges for that procedure, at the time of scheduling.

I further understand that such deposits shall become the property of the practice upon payment, shall not accrue interest in my name, and shall be non– refundable unless I cancel or postpone the procedure, at least five (5) days prior to the scheduled procedure date. Upon cancellation refunds by five day notice (5), in accordance with the practice's policies concerning cancellation refunds, I may be eligible to receive a refund. I understand that upon proper cancellation, the amount of the deposit to be refunded shall be refunded to me within ten (10) days by practice check, and that should I thereafter choose to reschedule the procedure it will be at the then–applicable fee schedule for that procedure.

Delinquent Bills and Collections
I understand that any bills which have remained outstanding forty–five days from date of service shall be considered delinquent and subject to referral to an attorney or a collection agency. I agree to pay all costs of collection, including without limitation court costs, agency fees and attorney fees through all trials and appeals, and 1% rate interest at the statutory rate on such delinquent amounts.

I, the undersigned, do hereby acknowledge receipt of this policy; acknowledge I have been given ample time and opportunity to read, understand, and ask all questions regarding this policy, and affirmatively accept the terms and conditions herein (either personally if patient or on behalf of patient if guarantor)

Signature: _____ Date: _____

If Guarantor, Relationship to Patient: _____

Received and accepted by Dr. Robert Orta's Office by _____

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CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A - PATIENT GIVING CONSENT

Name _____ Date _____
Last First

Address _____ Apt # ___City _____ State _____ Zip _____

Phone _____ Cell Phone _____

E-mail _____ Social Security # _____

Patient # _____

SECTION B - TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS 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, of the uses and disclosures we may make of your protected health information, and of other important matters about 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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Emmy Gomez **Telephone:** (813) 238-0411 **Fax:** (813) 238-5341 **Address:** 801 W. Dr. Martin Luther King Jr. Blvd., Tampa FL, 33613

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 Contact Person listed above. 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.

Fees & Payments
Although we accept payments from your insurance company toward your account, you are responsible for your full account. I am aware that they accept Master Card and Visa. I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. 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.

Signature of Guarantor: _____ Date: _____

Signature
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 heath care operations.

Signature: _____ Date: _____

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

Personal Representative's Name: _____ Relationship to Patient: _____
YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Patient, Parent or Guardian _____ Date _____

Doctor _____

Witness _____ Witness _____

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FINANCIAL POLICY AND PATIENT CONSENT FORM

Dr. Robert Orta D.D.S., P.A. recognizes the need for a clear understanding between patient and medical provider regarding financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

1. PAYMENT:
Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, we will begin various collection activities including, but not limited to submitting the past due account to a collection agency.

2. SELF PAYMENT (Private, Cash Payment):
If you have no insurance coverage, we require an advance payment for professional services.

3. In the event that my insurer does not pay all of the medical charges incurred, I hereby authorize Dr. Robert Orta D.D.S., P.A. to automatically charge the credit or debit card account listed below for the remaining balance due.

Cardholder Signature _____ Date _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ Master Card ☐ Visa ☐ American Express ☐ Discover Card

Number _____

Expiration Month _____ Expiration Year _____

Cardholder Signature _____ Date_____/ _____/ _____

Security Code _____

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FINANCIAL POLICY AND PATIENT CONSENT FORM

NOTICE

Dr. Robert Orta D.D.S., P.A. does not send out notification prior to charging credit and debit cards, so please make sure that you have funds available on the above account. You should receive a statement from your insurer indicating the amount they paid and the amount that is your responsibility. If there is a balance that is your responsibility, your credit or debit card will be charged approximately 3 days after the insurer's statement date.
Thank you!

Patient Name (Please print) _____ Patient Date of Birth _____

Signature (Insured/Guardian) _____ Date _____