PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY# _____ BIRTHDATE _____
MONTH DAY YEAR

ADDRESS _____
STREET APT # CITY STATE ZIP

TELEPHONE _____
HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED

IF NO INSURANCE COMPLETE FOR RESPONSIBLE

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

SECONDARY INSURED

LAST FIRST M

STREET CITY STATE ZIP

HOME WORK CELL E-MAIL

BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

EMPLOYER DENTAL INS. CO

SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

Has any member of your family ever been treated in our office?

☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental histories and other information about my dental treatment to third party payers and/or other health professionals.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

SERVICE CHARGE

If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1% per month. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney's fee incurred to effect collection of this account or future outstanding accounts.

HEALTH HISTORY

Patient's Name _____ 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 change 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 illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. Height _____ Weight _____
7. **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, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? ..... 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. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - 0. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - S. HIV, AIDS or ARC? ..... Y N
8. **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, 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. Any regular prescription medicine, pills or drugs If Yes, please list: _____

     _____
   - J. Herbal or Holistic remedies, Vitamins or over-the-counter medications? ..... Y N If Yes, please list: _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, 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. Other allergies or reactions? Please, list ..... Y N

     _____

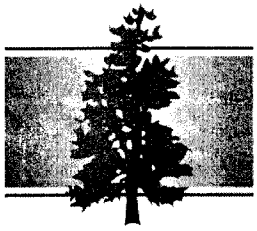
     _____
10. Do you smoke or chew Tobacco? ..... Y N How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FEMALES 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 Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

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

Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Doctor's Initials



WILLIAMS & TANNYHILL
ORAL & MAXILLOFACIAL
SURGERY

OUR OFFICE FINANCIAL POLICY

Welcome to our office. We at Dr. Williams and Dr. Tannyhill's office are proud to be a team of health care professionals whose goal is to provide you with the highest quality and most cost-effective care possible. We are also aware that unexpected health care costs can significantly impact your budget and we want to make our services as affordable as possible. In order to assist you with your health care investment, we provide the following payment options and ask that you read the following information.

The patient (or parent/legal guardian, if patient is a minor) is responsible for payment in full at the time our services are rendered. Acceptable forms of payment for these services are CASH, PERSONAL CHECK, MAJOR CREDIT CARD OR FINANCING THROUGH CARECREDIT AND ALPHAEON.

INSURANCE

We will gladly estimate your deductible, your portion of treatment costs, and bill your insurance company for your treatment fees, all at no extra cost to you. The estimated amount not covered by your insurance company is due at the time the treatment is rendered. Our estimates are subject to final approval by your insurance company, therefore, YOUR EXACT PORTION OF TREATMENT COSTS CANNOT BE DETERMINED UNTIL WE HAVE RECEIVED THE FINAL PAYMENT FROM YOUR INSURANCE COMPANY. If you have a balance remaining after insurance pays, you will be sent a final statement at that time. We do not bill secondary insurance companies, but we will provide you with copies of the needed information so that you can forward them to your secondary insurance company for reimbursement.

Please remember that your insurance is your responsibility. While we are happy to help you with claims submission, we can make no guarantee about insurance payment. We allow 45 days for your insurance company to make payment. After this time all inquiries and follow up become your responsibility. No finance charges will be applied if all balances are paid in full within 90 days of date of service.

PRE-AUTHORIZATION OF INSURANCE BENEFITS

Pre-authorization of insurance benefits may be in your best interest. Many patients are uncertain if recommended treatment is covered by their insurance plan, or what percentage the insurance may pay for covered benefits. In some cases, insurance companies do require pre-authorization for any treatment that will be over a certain dollar amount or certain types of treatment. In these situations, we will be happy to send the required information to your insurance company for pre-authorization consideration. This process normally takes 3 to 6 weeks for insurance companies to process the paperwork and get it back to us. Emergency treatment is normally excluded from this pre-authorization process.

PAYMENT INFORMATION

Payment options: Financial options are discussed during the initial visit. Dr. Williams and Dr. Tannyhill along with their business team are committed to providing excellent care and guiding patients in choosing the best payment option for their individual needs. We accept CASH, PERSONAL CHECK, VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS OR FINANCING THROUGH CARE CREDIT and ALPHAEON

.

Signature of Patient/Parent or Legal Guardian **Today's Date**

WILLIAMS & TANNYHILL
ORAL & MAXILLOFACIAL
SURGERY

Dr. Bryce Williams & Dr. R. John Tannyhill

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

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 any member of Dr. Williams and Dr. Tannyhill's staff at:

Telephone: 303-493-1933 Fax: 303-493-1934

Address: 14000 E. Arapahoe Road, Suite 320, Centennial, CO 80112

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. 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.

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.

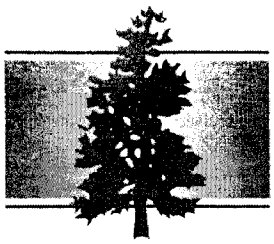
Signature: _____ **Date:** _____

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.



WILLIAMS & TANNYHILL
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COMMUNICATION CONSENT FORM

Patient Name:_____ **Date Of Birth:**_____

I authorize the office of Williams & Tannyhill Oral & Maxillofacial Surgery to speak with the following individuals about my care

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone: _____ Phone: _____

Please be aware if you choose to leave the above section blank we will be **unable** to discuss your treatment, appointments, billing information, etc.. with **anyone** who may call on your behalf.

Emergency Contact

Name_____

Address_____

Telephone #_____

Pharmacy Name and Location_____ Phone #_____

_____

Patient or Guardian's Signature **Date**