William B. Bohannan DDS, MD
Board Certified by the American Board of Oral and Maxillofacial Surgery
Oral & Maxillofacial Surgery
www.wboms.com

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To our patients,

We welcome you to our practice and we look forward to meeting you for your consultation. Prior to your appointment please take a moment to complete our financial policy and registration form. To expedite your appointment please complete the required documentation. Please bring your referral form, any x-rays you may have and your medical and dental cards. Please note that additional x-rays may be requested by Dr. Bohannan as part of your evaluation, diagnosis and treatment. The need for additional x-rays can only be determined by the doctor. Furthermore, please be prepared to provide us with your dental and medical plan information. This information is not transferred to us from your referring doctor's office. Our standard consultation fee is $96.00. Dental implant evaluations, cosmetic service consultations, orthognathic and problem focused exams are $185.00. The fees can vary based on the complexity of consultation. The panoramic x-ray fee is $110.00. If you have a dental benefit, this fee will be submitted by our office for payment. However, it is your responsibility to be informed about your dental plan. We cannot guarantee payment from your dental plan for services rendered. As a courtesy to you, we will be happy to research your dental and/or medical plan benefits during your consultation appointment and provide you with our fees for services. Once we confirm your dental and/or medical coverage, you will be asked to pay an estimated co-payment at the time of your service. All minors (under the age of 18) must be accompanied by a parent or legal guardian. We will not be able to perform an exam and/or surgery without a parent or legal guardian present. We strongly suggest that all parents and/or guardians are present at the consultation appointment. We will be reviewing important information for the surgery at this appointment. Please be informed that parent(s) and/or guardian(s) are not permitted in the surgical room during surgery. Parent(s), guardian(s) and/or patient drivers are required to be present in our waiting room during surgery.

Should you need to change your appointment, please be courteous and provide us at least 48 hours notice. If you are running late for your appointment, please call to let us know. If you are more than 10 minutes late for your appointment (surgery or consultation) we respectfully reserve the right to reschedule your appointment. Consultation appointments not cancelled with 24 hours notice will be charged $50.00. Surgery appointments not cancelled with 24 hours notice will be charged $100.00. Once your consultation is complete, we will be able to schedule your surgery appointment.

For more information on the services and procedures performed by Dr. Bohannan, please find the website at www.wboms.com.

Sincerely,

The offices of William B Bohannan DDS, MD

WELCOME TO DR. BOHANNAN'S OFFICE

PATIENT INFORMATION

Date ______________

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ____________ M.I.____ Last Name ____________ Nickname ____________

Sex: ❑ Male ❑ Female Birth Date ____________ Age ______ Soc. Sec. # ____________ E-mail ____________

Street ____________ City ____________ State ______ Zip ______

Home Tel.(______) ____________ Cell.(______) ____________ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist ____________ Medical Doctor ____________ Referred By ____________

Driver's Lic.# ____________ Nearest relative not living with you ____________ Tel.(______) ____________

Employer ____________ Bus. Tel.(______) ____________ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card ❑ Care Credit

Who is filling out the form? ❑ Patient ❑ Parent ❑ Guardian ❑ Caregiver ❑ Friend Name ____________

Is patient a minor? ❑ Yes ❑ No Who does the patient live with? ❑ Natural Dad ❑ Natural Mom ❑ Both ❑ Guardian ❑ Other ____________

Who will be responsible for your account?

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

(If self, skip to next section)

Name ____________ S.S.# ____________ Birth Date ____________ Age ______ Tel.(______) ____________

Street ____________ City ____________ State ______ Zip ______

Employer ____________ Bus. Tel.(______) ____________

Please Note: If someone else other than yourself is to be primarily responsible for the account, if you are 18 or older you will have a co-responsibility for any portion of the account not paid by the primary party.

Spouse or other guarantor information (*if different from above*)

Name ____________ Relation ____________ S.S.# ____________ Birth Date ____________

Street ____________ City ____________ State ______ Zip ______

Tel. (______) ____________ Employer ____________ Bus. Tel.(______) ____________

INSURANCE INFORMATION

1.I0

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address ____________

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ____________

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

❶

1.I1

Employer ____________

Bus. Address ____________

Bus. Tel.(______) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________

____________ Tel.(______) ____________

Group # ____________ **Group Name** ____________

Insured Party ____________ Relation to Patient ____________

Sex: ❑ M ❑ F Birth Date ____________

Street ____________

City, State, Zip ____________

Tel.(______) ____________ S.S. # ____________

I.D. # ____________

PRIMARY MEDICAL INSURANCE COMPANY

Employer ____________

Bus. Address ____________

Bus. Tel.(______) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________

____________ Tel.(______) ____________

Group # ____________ **Group Name** ____________

Insured Party ____________ Relation to Patient ____________

Sex: ❑ M ❑ F Birth Date ____________

Street ____________

City, State, Zip ____________

Tel.(______) ____________ S.S. # ____________

I.D. # ____________

SECONDARY DENTAL INSURANCE COMPANY

❷

1.I1

Employer ____________

Bus. Address ____________

Bus. Tel.(______) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________

____________ Tel.(______) ____________

Group # ____________ **Group Name** ____________

Insured Party ____________ Relation to Patient ____________

Sex: ❑ M ❑ F Birth Date ____________

Street ____________

City, State, Zip ____________

Tel.(______) ____________ S.S. # ____________

I.D. # ____________

SECONDARY MEDICAL INSURANCE COMPANY

Employer ____________

Bus. Address ____________

Bus. Tel.(______) ____________ Plan ____________

Ins. Co. Name ____________

Address ____________

____________ Tel.(______) ____________

Group # ____________ **Group Name** ____________

Insured Party ____________ Relation to Patient ____________

Sex: ❑ M ❑ F Birth Date ____________

Street ____________

City, State, Zip ____________

Tel.(______) ____________ S.S. # ____________

I.D. # ____________

HEALTH HISTORY

To our patients: Although oral surgeons primarily 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 may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit

	Yes	No
98. Are you experiencing any pain, discomfort, and/or swelling at this time?	❑	❑
99. Are you in good health? Height Weight	❑	❑
100. Have there been any changes in your general health in the past year?	❑	❑
101. Are you under the care of a physician? Date of last visit	❑	❑
If so, for what are you being treated?		
102. Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
If so, describe		
103. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, describe where*	❑	❑
104. Do you have a prosthetic joint/implant? *If so, describe where*	❑	❑
105. Have you had a heart valve replacement or vascular graft?	❑	❑
106. Have you ever had a general anesthetic or sedation for a procedure?	❑	❑
If you had general anesthetic, did you have any problems associated with it? (Nausea, difficulty breathing, etc.) ❑ Yes ❑ No *If so, please describe*		
107. Is there a family history of general anesthetic difficulties?	❑	❑
If so, please describe		
108. Do you take antibiotics prior to dental or other procedures?	❑	❑
109. Do you have difficulty or shortness of breath walking 2 blocks or 1 flight of stairs?	❑	❑
110. Do you have to sleep with more than 1 pillow to prevent shortness of breath?	❑	❑
111. Do you have, or recently had (within 2 weeks) a cold, stuffy nose, fever, sore throat, and or cough?	❑	❑
112. Do you take or have you taken cortisone, prednisone or other steroids in the last 2 years?	❑	❑
113. Have you been to the emergency room or admitted to the hospital in the last 5 years?	❑	❑
If so, please describe		
114. Do you use recreational drugs like marijuana, cocaine, heroin, amphetamines, etc.?	❑	❑
115. Are you taking any holistic or herbal medications or supplements? (Ginko, St. John's wort, etc.)	❑	❑
List		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
116 Organ transplants?			
117 Rheumatic fever?			
118 Damaged heart valves / mitral valve prolapse / Atrial fibrillation?			
119 Heart murmur?			
120 High blood pressure?			
121 Low blood pressure?			
122 Chest pain / angina?			
123 Heart attack(s)?			
124 Irregular heart beat (Arrhythmia)?			
125 Cardiac pacemaker?			
126 Heart surgery?			
127 Congestive heart failure?			
128 Bronchitis, chronic cough?			
129 Asthma?			
130 Hay fever / sinus problems?			
131 Snoring / sleep apnea?			
132 Difficult breathing / other lung trouble?			
133 Tuberculosis?			
134 Emphysema?			
135 Do you smoke?			
136 Do you use chewing tobacco?			
137 Blood transfusion?			
138 Blood disorder such as anemia?			
139 Porphyria?			
140 Bruise easily?			
141 Bleeding tendency/abnormal bleeding?			
142 Hepatitis, jaundice, or liver disease?			
143 Infectious mononucleosis?			
144 Gallbladder trouble?			
145 Spleen Removal?			
146 Fainting spells?			
147 Convulsions / epilepsy?			
148 High cholesterol / high triglycerides			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
149 Stroke?			
150 Thyroid trouble?			
151 Diabetes?			
152 Low blood sugar?			
153 Kidney trouble?			
154 Are you on dialysis?			
155 Swollen ankles, arthritis or joint disease?			
156 Stomach ulcers?			
157 Contagious diseases?			
158 Sexually transmitted diseases?			
159 Are you immunosuppressed? possibly from transplant surgery, etc.			
160 Problems with the immune system? possibly from medication / surgery, etc.			
161 Delay in healing?			
162 A tumor or growth (cancer)?			
163 Radiation therapy / chemotherapy?			
164 Chronic fatigue / night sweats?			
165 Are you dieting (taking diet pills/meds)?			
166 A history of drug abuse?			
167 A history of alcohol abuse?			
168 Contact lenses?			
169 Eye disease / glaucoma?			
170 Mental health problems?			
171 A removable dental appliance?			
172 Pain and clicking of jaws when eating?			
173 Malignant hyperthermia?			
174 **IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
175 Who is driving you home?			

MEDICATION – Are you now taking. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			

206 Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:

207 Any inhalers or nasal sprays (albuterol, atrovent, flonase, etc.), please list:

208 Please list any medications you are currently taking:

____

____

ALLERGIES – Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
209	Local anesthetic (numbing med.)?			
210	Penicillin / amoxicillin?			
211	Other antibiotics?			
212	Sulfa Drugs?			
213	Sodium pentothal, Valium, or other tranquilizers?			
214	Aspirin?			
215	Codeine or other narcotics?			
216	Other medications?			
217	Latex?			
218	Soy?			
219	Eggs / Yolk?			
220	Sulfites?			

221 Please list any other drug allergies and / or allergies other than drugs:

____

Is there any condition concerning your health that the Doctor should be told about?

❑ **Yes** ❑ **No** (***if so, describe***) ______________________________

____

Do you wish to speak to the doctor privately about anything?

❑ **Yes** ❑ **No**

Is there a **FAMILY HISTORY** of:

301 **Cancer:**	❑ Yes ❑ No
302 **Diabetes:**	❑ Yes ❑ No
303 **Heart Disease:**	❑ Yes ❑ No
304 **Anesthetic Problems:**	❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name ______________________________

Home Tel.(______) ______________________________

Bus. Tel.(______) ______________________________

IS THIS VISIT RELATED TO AN ACCIDENT?

Date of Injury ______________________________

Automobile:	❑ Yes	❑ No
Work Related:	❑ Yes	❑ No
Other:	❑ Yes	❑ No

Insurance company handling this claim ______________________________

Claim number ______________________________

Name of Attorney / Adjustor ______________________________

Telephone Number (______) ______________________________

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____ / _____ / _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills / shots? ❑ Yes ❑ No

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

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 / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES & PAYMENTS: Dr. Bohannan and his staff are committed to providing you with exceptional care and open communication regarding your investment in your oral health. We make every effort to keep down the cost of your oral surgical 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.

We need the above information so that we can help you obtain the dental and/or medical insurance benefits you are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a "pre-determination" of benefits or in some cases obtaining the information by phone. We can NEVER guarantee payment by your insurance company. The insurance company's contract is with you and your employer or you alone and is not the responsibility of this office. A separate financial policy will be provided to you.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

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 patient: *(Parent or Guardian if minor)* X **Date:** X

AUTHORIZATION: I authorize my surgeon and his / her designated staff, to perform a comprehensive oral maxillofacial and physical exam, 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. I understand that any patient under the age of 18 must be accompanied by a parent or legal guardian.

X **Date**

X **Signature of patient** *(Parent or Guardian if minor)*

Witness: X

Doctor: X

TO ALL OUR PATIENTS: Out of respect and courtesy to our patients, we have implemented the Health Information Privacy Policy and Procedures. We do this as a matter of sound business practice, to protect the interests of our patients; and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If you have any questions about our Health Information privacy and procedures, please do not hesitate to ask for a copy. I hereby acknowledge that a copy of this office's Notice of Privacy Practices (HIPAA) has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice. Furthermore,I authorize pathologic assessment of oral tissue by Oral Pathology Diagnostic Service or other Pathology Laboratories (IF INDICATED).

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

FINANCIAL POLICY

To avoid possible future questions between you, your insurance company and this office, we want you to understand this office's financial policy.

1. ***Understand that you are financially responsible for any and all costs of services rendered***.
2. As a courtesy to you, we will bill your insurance company. The filing of an insurance claim(s) is a service provided without charge and **in no way relieves you of responsibility for your bill.**
3. If after 60 days we have not received payment from your insurance company, the balance is immediately due in full. You will then need to arrange reimbursement personally or you need to contact and arrange reimbursement from your insurance company. We can help you with that procedure. Ultimately it is up to you to see that the insurance company pays on time.
4. Unless otherwise agreed between your insurance company and this office, we will collect between 20-30% of the estimated fees prior to or at the time of services. This 20-30% is the typical amount that you are usually responsible for based on your insurance policy.
5. You must inform this office immediately if there is any change in your insurance coverage, carrier or policy.
6. Understand that where appropriate, credit bureau reports may be obtained.
7. In the event payments are not received by the agreed upon dates, a finance charge of 1-1 ½ % per month (18%APR) will be added to your account. In addition, we will report any delinquencies to credit bureaus and elect to send delinquencies to a collection agency or small claims court. You will be responsible for any fees (collection, attorney's, court costs, etc.) associated with the collections process.
8. There is a $35.00 fee on returned checks.
9. We charge $50.00 for non-surgical appointments (consultations, office visits) not cancelled within 24 hours.
10. We charge $100.00 for appointments that are missed when surgery was scheduled. Before your surgery, pharmaceuticals, sutures, sterile gauze, and various other items are opened for your case and cannot be reused.
11. You will receive a monthly bill. This bill will reflect the total amount due. If your insurance company has not sent their portion, the insurance's portion will be reflected in the total.
12. Communication is the cornerstone of any good relationship. If you are having problems with your bill, paying your portion, and/or communicating with your insurance company in any way, please contact us. We are here to help.
13. We do offer financing through ***Care Credit*** if you are having difficulty with your bill and may be able to offer 3 month in office financing.

I certify that I understand the above policy that I am an adult over the age of 18, and that my minor/child, spouse, and/or myself is covered by insurance with

____[*name of insurance company(ies)*].

I assign directly to Dr. Bohannan and his staff all insurance benefits and authorize the release of any information necessary to secure the payment of my benefit(s) and/or any charges incurred on my account.

____________________________________ ______________________________ _______

Responsible party signature *Relationship* *Date*

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