FOR OFFICE USE ONLY ☐INS ☐SELF

PATIENT INFORMATION

David C. Hoffman, D.D.S., F.A.C.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Lydia J. Lam, D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Attending, Oral & Maxillofacial Surgery, SIUH

Emad Abdou, D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology
Pediatric Oral & Maxillofacial Surgery

Mark Goodenough, D.D.S., M.D.
Oral & Maxillofacial Surgery

Welcome to our office!

Please provide us with the information requested below, along with **A COPY OF BOTH YOUR DENTAL AND MEDICAL INSURANCE CARDS.** All information is kept confidential.

Patient's Name: ______________________ Today's Date: ______________

Sex: M F Age: _____ Birth Date: ____________ SS #: ________________

Address: ____

City: ______________________ State: ____________ Zip: ________

Home Phone #: ____________ Work: ____________ Cell: ____________

Spouse's/Parent's Name: ____________________________________

Policyholder's Name: ______________________ **Birth Date:** ______________

SS #: __________________ **Relationship to Patient:** __________________

Address: ____

City: ______________________ **State:** __________ **Zip:** __________

Primary Dental Insurance: ____________ **Policy ID #:** ____________ **Group #:** ____________

Mailing Address: ____

Secondary Dental Insurance: ____________ **Policy ID #:** ____________ **Group #:** ____________

Mailing Address: ____

Primary Medical Insurance: ____________ **Policy ID #:** ____________ **Group #:** ____________

Mailing Address: ____

Secondary Medical Insurance: ____________ **Policy ID #:** ____________ **Group #:** ____________

Mailing Address: ____

Physician: ______________________ Referring Dentist: ______________________

Orthodontist: ____

Reason for Visit: ____

How did you hear about our office? ______________________________

256-C Mason Avenue, 3rd Floor
Staten Island, NY 10305

1441 South Avenue, Suite 707
Staten Island, NY 10314

General questions: **info@sioms.us**
Referrals and xrays: **xray@sioms.us**

T: 718.226.1251
F: 718.226.1252

www.statenislandoralsurgery.us

STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

ASSIGNMENT OF BENEFITS

David C. Hoffman, D.D.S., F.A.C.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Lydia J. Lam, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Attending, Oral & Maxillofacial Surgery, SIUH

Emad Abdou, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology
Pediatric Oral & Maxillofacial Surgery

Mark Goodenough, D.D.S., M.D.
Oral & Maxillofacial Surgery

Name of Insurance: ____

Policy Holder's Name: ______________________ Social Security #: __________________

Employer: ____

Policy ID #: ______________________ **Policy Group #**: ______________________

ADDRESS WHERE CLAIM FORMS ARE TO BE MAILED:

Street Address: ____

City: ______________________ State: __________________ Zip: __________

If related to an automobile accident: D/A ____________ Claim #: ______________________

Claims Adjuster: ______________________ Phone #: ______________________

The following must be signed in order for this office to release information to your insurance company regarding your treatment and claim. I authorize release of any information to the insurance company relating to my claim.

Patient Signature: ________________________________ Date: ______________
(or legal guardian, if a minor)

ASSIGNMENT OF BENEFITS GUARANTEE TO COOPERATE

I authorize, assign, and direct payment of **no-fault insurance benefits** to the office of Drs. Hoffman, Lam, Abdou and Goodenough for monies due on the bill(s) that relate to services rendered. I understand that neither pre-authorization nor pre-determination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the no-fault insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against the no-fault insurance carrier, if there is no timely payment of the claim.

Patient Signature: ________________________________ Date: ______________

I authorize, assign, and direct payment of **health insurance benefits** to the office of Drs. Hoffman, Lam, Abdou and Goodenough for monies due on the bill(s) that relate to services rendered. I understand that neither pre-authorization nor pre-determination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the health insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against the health insurance carrier, if there is no timely payment of the claim.

Patient Signature: ________________________________ Date: ______________

256-C Mason Avenue, 3rd Floor
Staten Island, NY 10305

1441 South Avenue, Suite 707
Staten Island, NY 10314

General questions: **info@sioms.us**
Referrals and xrays: **xray@sioms.us**

T: 718.226.1251
F: 718.226.1252

www.statenislandoralsurgery.us

STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

PATIENT CONTACT INFORMATION

David C. Hoffman, D.D.S., F.A.C.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Lydia J. Lam, D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Attending, Oral & Maxillofacial Surgery, SIUH

Emad Abdou, D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology
Pediatric Oral & Maxillofacial Surgery

Mark Goodenough, D.D.S., M.D.
Oral & Maxillofacial Surgery

Please be advised that the office will be contacting you to confirm your next appointment a few days in advance. Make sure all contact information is filled out, and check off the best way to contact you. Thanks!

______ Cell Phone: ________________________________

______ Home Phone: ______________________________

______ Email: ____________________________________

______ Text Message: _____________________________

PHARMACY CONTACT INFORMATION

As of March 21, 2016, New York State law requires that all prescriptions be sent to the pharmacy electronically. Please provide us with the name, address, and phone number of your pharmacy.

Pharmacy Name: _____________________________________

Address: ____

City: ___________________ State: ______________ Zip: _________

Pharmacy Phone: _____________________________________

STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

HEALTH HISTORY

PATIENT'S NAME: ______________________________ TODAY'S DATE: ____________________

ANSWER ALL QUESTIONS BY CIRCLING YES OR NO

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 currently 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: ____________

DO YOU HAVE OR HAVE YOU EVER HAD:

7. Rheumatic fever or rheumatic heart disease?....... Y N
8. Congenital heart disease?.................................. Y N
9. Cardiovascular disease (heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?.. Y N
10. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?.................... Y N
11. Seizures, convulsions, epilepsy, fainting, dizziness, psychiatric treatment, or other nervous disorder?.. Y N
12. Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?............. Y N
13. Liver disease (jaundice, hepatitis)?...................... Y N
14. Kidney disease?.. Y N
15. Diabetes?.. Y N
16. Thyroid disease (goiter)?.................................. Y N
17. Arthritis?.. Y N
18. Stomach ulcers or colitis?.................................. Y N
19. Glaucoma?.. Y N
20. Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)?............................. Y N
21. Radiation (x-ray) treatment for cancer?................ Y N
22. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
23. Sinus or nasal problems?.................................. Y N
24. Any disease, drug, or transplant operation that has depressed your immune system?.................. Y N
25. HIV, AIDS, or ARC?.. Y N

ARE YOU USING ANY OF THE FOLLOWING?

26. Antibiotics?.. Y N
27. Anticoagulants (blood thinners)?.......................... Y N
28. Aspirin/drugs such as Motrin (ibuprofen), Aleve? Y N
29. High blood pressure medications?....................... Y N
30. Steroids (Cortizone, etc.)?................................. Y N
31. Tranquilizers?.. Y N
32. Insulin or oral anti-diabetic drugs?...................... Y N
33. Digitalis, Inderal, nitroglycerin, or other heart drug? Y N
34. Any regular medicine, pills, or drugs (either over-the-counter or prescription)? If yes, please list:

____

____

____

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY ADVERSE REACTION TO:

35. Local anesthesia (Novocain, etc.)?...................... Y N
36. Penicillin or other antibiotics?............................ Y N
37. Sedatives, barbiturates?.................................... Y N
38. Aspirin or ibuprofen?.. Y N
39. Codeine or other painkillers? .... Y N
40. Latex or rubber products?.................................. Y N
41. Other allergies or reactions? Please list:

____

____

42. Do you smoke or chew tobacco?......................... Y N
How much per day? ____________________
43. Is there any past history of alcohol or chemical dependency or an emotional disorder that may affect the care we provide you?......................... Y N
44. Have you ever had any serious problems associated with any previous dental treatment?... Y N
45. Have you or has an immediate family member had any problem associated with intravenous anesthesia? Y N
46. Do you have any other disease, condition, or problem not listed above that the doctor should know about?.. Y N
47. Do you wish to talk to the doctor privately about anything?... Y N

FOR WOMEN ONLY:

48. Are you pregnant, or **is there any chance** you might be pregnant?.. Y N
If you are using oral contraceptives, it is important to 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 in place of one complete cycle of birth control pills after your course of antibiotics or other medication is completed. Please consult your physician for further guidance.

Patient Signature: ____________________________

Date: ____________________________________

ALL RESPONSES ARE KEPT CONFIDENTIAL

STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

FINANCIAL RESPONSIBILITY

David C. Hoffman, D.D.S., F.A.C.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Lydia J. Lam, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Attending, Oral & Maxillofacial Surgery, SIUH

Emad Abdou, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology
Pediatric Oral & Maxillofacial Surgery

Mark Goodenough, D.D.S., M.D.
Oral & Maxillofacial Surgery

Like most group insurance policies, my dental policy may contain certain exclusions, waiting periods, reductions of benefits, limitations, and other terms for keeping them in force.

I understand that the fees I have been quoted, as well as the amount I have just paid, are estimates, based on the information Drs. Hoffman, Lam, Abdou and Goodenough have received from my insurance company. This is not a guarantee of my financial responsibility. The final benefit determination can only be made when a written Explanation of Benefits is received from my insurance company. If more monies are due, I will receive a copy of this EOB with an itemized bill from Drs. Hoffman, Lam, Abdou and Goodenough.

Patient Signature: ________________________________ Date: ______________________

256-C Mason Avenue, 3rd Floor
Staten Island, NY 10305

1441 South Avenue, Suite 707
Staten Island, NY 10314

General questions: **info@sioms.us**
Referrals and xrays: **xray@sioms.us**

T: 718.226.1251
F: 718.226.1252

www.statenislandoralsurgery.us

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____________________________ Date of Birth: _____________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper cop of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____ Date: _______________________

Relationship to patient (if signed by a personal representative of patient): _________________

STATEN ISLAND
ORAL & MAXILLOFACIAL SURGERY

3D CONE BEAM CT SCAN

David C. Hoffman, D.D.S., F.A.C.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Lydia J. Lam, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Attending, Oral & Maxillofacial Surgery, SIUH

Emad Abdou, D.D.S.
Diplomate, American Board
of Oral & Maxillofacial Surgery
Diplomate, National Dental Board of Anesthesiology
Pediatric Oral & Maxillofacial Surgery

Mark Goodenough, D.D.S., M.D.
Oral & Maxillofacial Surgery

In some circumstances, a **3D Cone Beam CT scan** may be required in order to accurately and safely diagnose certain conditions pertaining to, but not limited to, implants, impacted teeth, orthognathic and pathology. Your doctor will determine if and when this Cone Beam CT scan is necessary. If so, please be aware that this Cone Beam CT scan is not covered by your insurance company. It is an out of pocket expense of $250.00 payable the day of the scan. This is in addition to any other services performed that you may be responsible for.

I, ______________________________ understand and agree to the above financial responsibility.
(print patient's name)

____ ________________________
Patient or guardian's signature Relationship to patient

____
Date

256-C Mason Avenue, 3rd Floor
Staten Island, NY 10305

1441 South Avenue, Suite 707
Staten Island, NY 10314

General questions: **info@sioms.us**
Referrals and xrays: **xray@sioms.us**

T: 718.226.1251
F: 718.226.1252

www.statenislandoralsurgery.us