ROLLE ORAL & FACIAL SURGERY
PATIENT REGISTRATION

NAME_____ DATE OF BIRTH_____ SS#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HM PHONE_____ WK PHONE_____ CELL_____

EMPLOYER_____ EMAIL ADDRESS_____

RESPONSIBLE PARTY (IF MINOR) _____ SPOUSE_____

DENTAL INSURANCE_____ ID#_____

POLICY HOLDER NAME_____ M / F SELF PARENT SPOUSE

DATE OF BIRTH_____ SS#_____ EMPLOYER_____

MEDICAL INSURANCE: _____ ID#_____

POLICY HOLDER NAME_____ M / F SELF PARENT SPOUSE

DATE OF BIRTH_____ SS#_____ EMPLOYER_____

SECONDARY INSURANCE (IF ANY)_____ **MEDICARE RECIPIENT** YES NO

POLICY HOLDER NAME_____ ID#_____ DOB:_____

**** IF YOU DO NOT HAVE AN INSURANCE ID #, PLEASE PROVIDE THE SS# OF POLICY HOLDER****

REFERRED BY_____ **DENTIST**_____ **ORTHODONTIST**_____

PRIMARY CARE PHYSICIAN_____

HOW DID YOU CHOOSE OUR OFFICE- REFERRAL LOCATION INSURANCE RELATIVE/FRIEND INTERNET

CONTRACT TO PAY FOR MEDICAL SERVICES

In consideration of professional services provided to the above patient, I/we agree to pay your reasonable and customary rates for these services in full, at the time of service, unless other arrangements have been made in advance. I/we authorize Dr. Richard Rolle Jr. to receive assignment of insurance payments. **If the customary charges are more than the benefits allowed under the responsible party's insurance plan, I/we agree to pay the difference.** I understand that a finance charge of 11% will be added to my outstanding balance after 60 days.

AUTHORIZATION TO RELEASE INFORMATION

Dr. Richard Rolle Jr. is hereby authorized to release any medical or incidental information that may be necessary either for medical care or for processing requests of financial benefits.

LEGAL RESPONSIBLE PARTY

If the patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. **By signing this form, you agree that you have been given and have had the opportunity to read our Notice of Privacy Practices.**

_____ _____

Patient Signature **Date**

_____ _____

Responsible Party Signature **Date**

PLEASE READ THE FOLLOWING BUSINESS POLICY CAREFULLY

The primary goal in this office is to provide you, the patient, with state of the art oral surgery treatment. At the same time, we hope to make this experience as pleasant and as comfortable as possible. We must, however, establish a strict business policy so that we can concentrate on your medical and dental care while keeping our administrative costs at a minimum.

At the time of your visit to our office, we will make every effort to provide you with the most accurate financial assessment of your specific treatment needs. It is sometimes impossible to anticipate every procedure in advance. Therefore, there may be some differences in what is expected before surgery and the final outcome. Again, we will make every effort to ESTIMATE, as close as possible, your specific treatment costs.

If you have medical and/or dental insurance, you must provide us with complete, current, information in order for us to file the insurance claim for you. We will contact your insurance carrier to verify eligibility, benefits, and copays. Please note that our office is not responsible for any incorrect information that is given to us by your insurance company – it is your responsibility (and to your advantage) to know your own insurance. Once we have verified your insurance, we will ESTIMATE, as accurately as possible, your portion that will be due at the time of service. In the event that the insurance company does not pay what we had anticipated, YOU WILL ULTIMATELY BE RESPONSIBLE FOR ANY OUTSTANDING BALANCE. On the other hand, if the insurance company pays more than what we had anticipated, you will be due a refund. Refunds are issued once a month and should be expected in the mail within the last two weeks of the month.

If you do not have any insurance coverage, we expect payment, in full, for any services rendered that day. If you are unable to pay for your treatment costs, we do offer two finance options available through Wells Fargo Financial. Applications can be taken over the phone and approval can be obtained the same day. For your convenience, we accept cash, check, and all major credit cards as forms of payment. Please note that there will be a $25.00 service fee applied to any and all checks returned from your bank unpaid. Payment, in full, for the bounced check and service fee is expected immediately upon your receipt of the bank's notice of the returned check. No partial payments will be accepted.

When your insurance has made payment and there is still a balance left on your account, you will receive a statement and payment will be expected in 30 days or less. Once your account balance goes over 120 days, it will be turned over to our collection agency. In this unlikely event, you will be responsible for any and all fees that our office incurs throughout the collection process. The collection agency can charge up to 40% of whatever is collected on the account and we can charge up to a 2% finance charge on the outstanding balance. These charges will automatically be added to your account.

FOR MEDICAL INSURANCE CLAIMS

If your medical insurance requires a referral from your primary care physician (PCP) to be examined and treated by a specialist, it is your responsibility to obtain that referral from your PCP. If your dentist refers you to our office for a medical condition that we will be billing to your medical carrier, you must contact your PCP before your visit to our office and go through the referral process. In the event that you come to this office unaware of needing a referral from your PCP, we will attempt to help in any way to obtain that referral for you. Please note that we cannot guarantee we will be able to get the referral. Any claims that are denied because there was no referral from the PCP on file with the medical insurance carrier will be the responsibility of the patient.

FOR DENTAL INSURANCE CLAIMS

Dental insurance carriers do not require that you have a referral from a primary care physician. If you are being treated for a dental condition, it is not necessary to obtain any referrals for billing claims to your dental carrier.

PATHOLGY CLAIMS

For those patients having lesions removed - specimens are taken to Lake Norman Pathology Associates or LabCorp for diagnostic examination. Any charges associated with the services at Lake Norman Pathology or LabCorp are the responsibility of the patient.

By signing this business policy, I verify that I have read carefully, completely understand, and fully agree to adhere to all the terms outlined above.

Signature _____ Date _____

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____ Sex: M / F Height:_____Weight: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

MEDICATION
ALLERGIES_____

Chief Dental Complaint: _____
_____

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name of my physician is:_____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? ..... Yes No
   If Yes_____
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... Yes No
   If Yes_____
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? ..... Yes No

9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies?..... Yes No
   If so, please list: _____
   _____

10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       If Yes Date of last attack_____
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
       If Yes, Do you take insulin and how often_____
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No

l. Respiratory problems, e .ıysema, bronchitis, etc. ..... Yes No
m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
n. Osteoporosis ..... Yes No
o. Stomach ulcer or hyperacidity ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough that produces blood ..... Yes No
s. Persistent swollen neck glands ..... Yes No
t. Low blood pressure ..... Yes No
u. Epilepsy or neurological disorder ..... Yes No
v. Cancer ..... Yes No
If Yes, What Kind _____
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
If Yes, what disease _____

11. Have you had abnormal bleeding? ..... Yes No
a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Have you had radiation therapy to the head, neck or jaws? ..... Yes No
15. Are you allergic to or have you had a reaction to:
a. Local anesthetics ..... Yes No
b. Penicillin or antibiotics ..... Yes No
c. Sulfa drugs ..... Yes No
d. Barbiturates or sleeping pills ..... Yes No
e. Aspirin ..... Yes No
f. Iodine ..... Yes No
g. Codeine or other narcotics ..... Yes No
h. Latex or rubber products ..... Yes No
i. Other ..... Yes No
16. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
If so, explain: _____
_____
17. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
If so, explain: _____
18. Do you smoke or chew Tobacco? ..... Yes No
How much? _____
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Yes No
20. Are you wearing contact lenses? ..... Yes No
21. Are you wearing removable dental appliances? ..... Yes No
22. Do you wish to talk with the doctor privately about anything? ..... Yes No

Women

20. Are you pregnant or trying to become pregnant ..... Yes No
21. Do you have problems associated with your menstrual period? ..... Yes No
22. Are you nursing? ..... Yes No
23. Are you taking birth control pills? ..... Yes No

Please explain any other health problems not discussed _____
_____
_____
_____

I have read and understand the above. Any questions I had about this form have been answered and understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:_____ Patient's Signature:_____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

Date:_____ Doctor's Signature:_____

Medical History Update:

Date	Comments	Signature

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

_____ _____

Patient Signature Date

_____ _____

Print Name Birth date

PLEASE CIRCLE IF ANY OF THE FOLLOWING PERTAIN TO YOU:

HEART PROBLEMS ASTHMA HEART ATTACK

SLEEP APNEA BREATHING PROBLEMS

DRUG/ALCOHOL USE HEPATITIS STROKE

TUBERCULOSIS EPILEPSY SEIZURES

PSYCHIATRIC TREATMENT

SEXUALLY TRANSMITTED DISEASE

AUTO IMMUNE DISEASE HIV/AIDS PACEMAKER

PREGNANT IMMUNE SYSTEM DISORDER

Please Sign: _____

Date: _____

ROLLE
ORAL & FACIAL SURGERY

How did you hear about Rolle Oral and Facial Surgery?

_____ Charlotte Hornets

_____ Charlotte 49ers

_____ Website

_____ Referral

_____ Radio

_____ Twitter

_____ Facebook

_____ Coffee News

_____ Harris Teeter Shopping Carts

_____ Pride Magazine

_____ The Peninsula Magazine

_____ Walk-In

_____ Google Search

_____ Insurance Company

_____ Other, Please specify_____

DR. RICHARD R. ROLLE, JR.
9615 Gilead Commons Circle, Suite B, Cornelius, NC 28031
RolleOralFacialSurgery.com • [illegible] • Fax: [illegible]