



Newport Beach Oral Surgery & Implants

PATIENT INFORMATION

Patient's Name _____ Date of Birth: _____
Cell # _____ Home # _____ Guardian _____ Guardian # _____
Mailing Address _____ City _____
State _____ Zip _____ Email Address _____
Employer _____ Occupation _____
Dental Insurance Co. _____ Subscriber ID # _____
Who may we thank for referring you to our office? _____

Welcome to our office! An accurate and complete health history will assist in coordinating your dental care.

MEDICAL HEALTH HISTORY

Do you have or have had any of the following?
(Please check all that applies)

- ☐ Abnormal Bleeding After Extractions, Surgery, or Trauma
- ☐ AIDS or HIV positive
- ☐ Alcoholism
- ☐ Allergies or hives
- ☐ Allergies or Hives
- ☐ Anemia or Blood Disorders
- ☐ Arthritis
- ☐ Artificial Joint or Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer or Tumor
- ☐ Diabetes
- ☐ Emotional Condition
- ☐ Epilepsy, Seizures, or Fainting Spells
- ☐ Hay fever or Sinus Trouble
- ☐ Heart Ailment or Angina
- ☐ Heart Murmur, Mitral Valve Prolapse or Heart Defect
- ☐ Hepatitis or other Liver Disease
- ☐ Herpes or Cold Sores
- ☐ High or Low Blood Pressure
- ☐ Kidney Disease
- ☐ Migraine Headaches or Frequent Headaches
- ☐ Neurologic Conditions
- ☐ Pacemaker
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Smoke, E-cigarettes or use chewing tobacco etc.?
- ☐ Tuberculosis or Other Lung Problems

Are you allergic to, or have you reacted adversely to any of the following:

- ☐ Antibiotics: Penicillin, Sulfa
- ☐ Aspirin
- ☐ Barbiturates, Sedatives or Sleeping Pills
- ☐ Codeine or Other Narcotics
- ☐ Epinephrine
- ☐ Latex materials
- ☐ Local Anesthetics ("Novocain")
- ☐ NSAIDS: Ibuprofen, Naproxen
- ☐ Other: _____

Are you taking any of the following?

- ☐ Antianxiety agents, Antidepressants or Tranquilizers
- ☐ Antibiotics
- ☐ Anticoagulants (blood thinners)
- ☐ Aspirin
- ☐ Blood Pressure Medicine
- ☐ Cancer or Chemotherapy drugs
- ☐ Heart Medication
- ☐ Insulin, Orinase, or other diabetes drug
- ☐ Nitroglycerin
- ☐ Osteoporosis (bone density) medicine
- ☐ Prescription Pain Medication
- ☐ Steroids: cortisone, prednisone
- ☐ Other: _____
- ☐ May be pregnant
Expected Deliver Date: _____
- ☐ Taking hormones or Contraceptives

Name of your physician: _____

Do you have any problems sleeping at night, fatigued during the day, or been told you snore at night?

Signature of Patient (or guardian) _____ Date: _____



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Note of Financial Responsibility

To Our Patients:

Our office understands the value of insurance benefits to our patients. As a valued patient, you are reminded that your dental insurance policy is an agreement between you and your insurance company, and not an agreement between the insurance company and this dental office. As a courtesy, if you have dental insurance we will file your insurance claims for you.

We kindly remind you that your treatment proposal based of your Insurance Plan is only an Estimation. Full payment is due upon services rendered.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 30 days from the date of service becomes the immediate responsibility of the patient and/or account holder. For insured patients: Your co-pay has been estimated to the best of our ability with the information that has been provided by your Insurance Provider. If you receive a discount off your treatment, there will be no remittance if your insurance payment is greater than the discount you were afforded.

Upon your first visit, Dr. Salib will require diagnostic radiographs or a CT scan to ensure proper diagnosis for your consultation appointment. There are fees for these procedures that you will be responsible for.

You are giving Newport Beach Oral Surgery and Implants permission to contact you on your cell phone to discuss account and insurance information with you.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 60 days of service with insurance denial will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 60 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance.

All Credit card and Cash Payments are Nonrefundable for initial consultation and Xray. There will be a 3% surcharge for all Credit Card payments.

Any attorney or collections fees as well as preparation time spent incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees.

Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a \$100 NSF check fee and may also subject you to court costs and attorney fees.



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Note of Cancellation and No-Show Policy

Office hours are by appointment only and we do value your time. This office is a private practice Newport Beach Oral Surgery & Implants and not a dental chain "clinic". Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments to complete as much of your work as possible in one appointment. We believe this type of scheduling will cause minimal disruption to your daily schedule and provide efficiency in completing your oral & maxillofacial surgery needs. We prefer to schedule surgical procedures during the morning to facilitate anesthesia considerations and to be able to have sufficient time to address any medical emergencies that may arise.

Personal emergencies and unforeseen patient treatment problems may arise causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. We request a 24hour cancellation notice for scheduled appointments. A cancellation fee of \$150 may be charged if a 24hour notice is not given.

Digital Copies of C.T. Scans are available with a service fee of \$250 and must be picked up in person.

I acknowledge having read the Note of Financial Responsibility Form & Cancellation/No-Show Policy in its entirety and agreed to be bound by all the terms and conditions herein.

Patient's Full Name: _____

Patient's Signature: _____

Date: _____



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Authorization to Release Photography or Digital Images

I, _____(name),

hereby authorize Dr. Salib or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I grant Dr. Salib and his/her practice permission to take and use photographs and digital images of me for the purpose of:

- ☐ Teaching (i.e. Educational materials)
- ☐ Marketing (i.e. Web site, brochures, etc.)
- ☐ Other: _____

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature _____

Date _____



Newport Beach Oral Surgery & Implants

Dr. Nader Salib

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:



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Credit Card Form

To Patient:

Pursuant to your proposed Treatment Plan, please note that this is Only an estimate of the co-pay owed. Any additional charges not paid by your insurance will be your responsibility to pay within 5 business days.

Our office policy requires our patients/guardian to provide Newport Beach Oral Surgery & Implants a valid credit card and CVV number to act as a deposit to guarantee payment of monthly Statement. If Patient fails to pay any statement within five (5) business days of the date due, then Newport Beach Oral Surgery & Implants is authorized to charge Patient's/Guardian's Credit Card for the payment of the outstanding balance.

Please complete the following:

Type of credit card _____

Credit Card number _____

Exp: _____

CVV code: _____

Patient full name: _____

Guardian: _____

Patient/Guardian Signature: _____

Date: _____

Patient/Guardian Email: _____