JEFFREY L. DONLEVY, D.D.S., M.D.
ABRAHAM ESTESS, D.D.S.
SAPNA LOHIYA, D.D.S.

ORAL and MAXILLOFACIAL SURGERY

Pharmacy Form

Please list the name, phone number, and address of the pharmacy that you would like us to submit your electronic prescription to.

Patient Name:_____

Pharmacy Name:_____

Pharmacy Adress and Phone#: _____

_____

_____

_____

_____

_____

New patient Form

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ABOUT THE PATIENT

Name: _____
Last First Middle

Birthdate: ____/____/____ Age: ____ SS#: ____- ____- _____

Street Address: _____ Apt#: _____

City: _____ Zip: _____ State: _____

Home Phone: _____ Cell Phone: _____

Email*: _____

*By providing my email I hereby consent to email communications regarding my treatment, insurance, account and special promotions. I understand that I may withdraw my consent at any time.

Employer: _____

Work Phone: _____

Spouse/Parent Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Referred to the Office By: _____

Current Dentist: _____

Date of last exam: ____/____/____

Current Orthodontist: _____

Date of last exam: ____/____/____

Medical Physician's Name: _____

Date of last exam: ____/____/____

Medical Physician's Phone: _____

DENTAL INSURANCE

Primary Dental Insurance

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS/ID#: _____

Subscriber's Birthdate: ____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company: _____

Please provide copy of dental insurance card.

Secondary Dental Insurance

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS/ID#: _____

Subscriber's Birthdate: ____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company: _____

Please provide copy of dental insurance card.

Medical Insurance

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's SS/ID#: _____

Subscriber's Birthdate: ____/____/____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company: _____

Please provide copy of medical insurance card.

I understand that the information given here is, to the best of my knowledge, correct. I also understand this information will be held in STRICT CONFIDENCE. It is my responsibility to inform this office of any changes in my medical or financial status. WITH MY INFORMED CONSENT, I AUTHORIZE ANY NECESSARY SURGICAL SERVICES INDICATED DURING DIAGNOSIS AND TREATMENT TO BE PERFORMED. If I have insurance, I hereby authorize my insurance benefits to be paid directly to the surgeon. I also authorize the surgeon and staff to release any information required for payment to be made. I understand that depending on my insurance coverage I may owe a balance after my insurance company has reimbursed the surgeon. l further understand that I WILL BE financially responsible for any balance that is due.

Patient Signature (Parent or Guardian if Patient is a MINOR): _____ DATE: ____/____/____

Medical History Questionnaire

JEFFREY L. DONLEVY, D.D.S., M.D.
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Date: ____/____/____ Patient Name:_____ Age: _____

There are many situations which can affect or be affected by the procedure or drugs used during your treatment in our office. Please fill out the following medical history questionnaire carefully and accurately. Please check Yes and No answers. Thank you.

1. What prescription, nonprescription, or herbal medications are you currently taking? _____
2. Please list any ALLERGIES or sensitivity to any medications. injections, or latex: _____
3. Has there been any change in your health in the last six months? ☐No ☐Yes If yes, explain: _____
4. Have you ever been hospitalized? ☐No ☐Yes If yes, for what reason: _____
5. Have you ever had surgery requiring a general anesthetic? ☐No ☐Yes Any complications with anesthesia? ☐No ☐Yes

Please list previous surgeries: _____

Have you within the last 6 months taken any of the following medications?

☐Yes ☐No Diabetes Medications (Insulin, etc.)
☐Yes ☐No Bone Density Medication (Fosamax, Aredia, Zometa, Boniva, etc.)
☐Yes ☐No Steroids (Cortisone, Prednisone, etc.)
☐Yes ☐No Blood Thinners (Plavix, Coumadin, etc.)
☐Yes ☐No Recreational Drugs (Cocaine, Marijuana, Ecstasy, Heroin, etc.)

WOMEN:
Is there any possibility that you are pregnant?
☐ No
☐ Yes - Please notify a staff member immediately.

Are you currently breastfeeding?
☐Yes ☐No

Are you taking birth control pills?
☐Yes ☐No

Please check Y for Yes or N for No for any of the following conditions that you have had or currently have:

☐Y ☐N Artificial Heart Valve
☐Y ☐N Heart Murmur
☐Y ☐N Rheumatic Heart Disease
☐Y ☐N Rheumatic Fever
☐Y ☐N Heart Attack
☐Y ☐N High Blood Pressure
☐Y ☐N Asthma
☐Y ☐N Tuberculosis
☐Y ☐N Malignant Hyperthermia
☐Y ☐N Epilepsy
☐Y ☐N Bleeding Problems

☐Y ☐N Diabetes
☐Y ☐N Kidney Disease
☐Y ☐N Liver Disease
☐Y ☐N Jaundice, Hepatitis
☐Y ☐N Thyroid
☐Y ☐N COPD/Emphysema
☐Y ☐N Psychiatric Treatment
☐Y ☐N Hormonal Disorders
☐Y ☐N Stomach Ulcer
☐Y ☐N AIDS or HIV
☐Y ☐N Glaucoma

☐Y ☐N Arthritis
☐Y ☐N Stroke
☐Y ☐N Shortness of Breath
☐Y ☐N Sinus Problems
☐Y ☐N Hip or Joint Replacement
☐Y ☐N Obstructive Sleep Apnea
☐Y ☐N Malignancies/Cancer
☐Y ☐N Radiation Treatment
☐Y ☐N Chemotherapy
☐Y ☐N Chest Pain/Angina
☐Y ☐N TMJ (Jaw Joint) Problems
☐Y ☐N Other: _____

Has anyone in your family had any of the following?
☐Y ☐N Heart Disease
☐Y ☐N Bleeding Problems
☐Y ☐N Anesthetic Complications
What?_____

Do you smoke?
☐Yes ☐No How much?____Pk/day. How many years?_____

Number of alcoholic drinks a day: _____

Do you wear contact lenses? ☐Yes ☐No

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Signature of Patient (Parent or guardian if patient is a minor): _____ DATE: ____/____/____

History reviewed by:_____ ☐HB ☐WC ☐CC

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ORAL and MAXILLOFACIAL SURGERY

DRS. DONLEVY, ESTESS AND LOHIYA

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.

PRINT NAME	SIGNATURE	DATE

FOR OFFICE USE ONLY

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

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

_____

_____

_____

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PATIENT NOTIFICATION OF MEDICARE NON-PARTICIPATION

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DEAR MEDICARE PATIENT:
Dental services are NOT covered by Medicare.
Please be advised that Drs. Donlevy, Estess and Lohiya are not providers for Medicare.
In certain cases, Medicare coverage is available for some related treatment procedures. Cysts of the oral region, tumors, biopsies of growths in the oral cavity and fractured jaws, may qualify for possible benefit coverage from the Medicare program.

If your case involves any of the above mentioned procedures, you have the option of selecting a Medicare provider/participant for your treatment. You must make this decision prior to being treated by Drs. Donlevy, Estess and Lohiya.

PLEASE READ AND SIGN:
I have been informed that Drs. Donlevy, Estess and Lohiya are not participants in the Medicare program. I understand and agree that I am therefore responsible for payment of services rendered by Drs. Donlevy, Estess and Lohiya.

PATIENT SIGNATURE OR LEGAL GUARDIAN _____ DATE _____

OFFICE WITNESS SIGNATURE _____ DATE _____