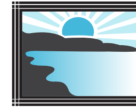
JEFFREY L. DONLEVY, D.D.S., M.D.
ABRAHAM ESTESS, D.D.S.
SAPNA LOHIYA, D.D.S.



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:____

Patient Height: ____________________ Weight:____________________

Pharmacy Address and Phone#: ________________________________

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____

SOUTH BAY
(310) 318-3333
1072 Aviation Blvd.
Hermosa Beach, CA 90254

WESTCHESTER
(310) 337-0007
8540 S. Sepulveda Blvd., Suite 709
Los Angeles, CA 90045

CULVER CITY
(310) 559-9490
10100 Culver Blvd., Suite C
Culver City, CA 90232

New Patient Form

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

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. I 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: ____ /____ /____

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Medical History Questionnaire

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

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

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

ORAL and MAXILLOFACIAL SURGERY

DRS. DONLEVY, ESTESS AND LOHIYA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

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

____

____

____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002)

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

PATIENT NOTIFICATION OF MEDICARE NON-PARTICIPATION

PATIENT NOTIFICATION OF MEDICARE NON-PARTICIPATION

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 infroned 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 ____________

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

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges in this office. If I am a cash patient, I understand all charges will be paid at the time of service, unless a written financial arrangement was made in advance. If I have insurance, I understand a deposit will be collected at the time of service. As a courtesy, Donlevy & Estess Oral Surgery Group will bill my insurance and once a determination is made on my claim(s), I will either receive a bill or a refund, depending on the outcome from my insurance company.

I understand that this office cannot guarantee coverage from insurance companies. Therefore, I will be fully liable for all treatment rendered. I agree to pay all late fees, collection costs, attorney fees, and any other charges that may be incurred to enforce collections of any outstanding amount.

Donlevy & Estess Oral Surgery Group accepts American Express, MasterCard, Visa, Discover and Care Credit. Financing options are always available.

CONSENT FOR FINANCIAL COMMUNICATION

I hereby authorize Donlevy & Estess Oral Surgery Group to discuss financial information with the following individual. I understand this person is not financially obligated to pay my outstanding bill(s), but, he/she may speak with the office regarding, but not limited to payments, refunds, insurance and payment arrangements.

Name:____

Relationship to Patient: ______________________________________

Phone Number: ____

____ ________________

PATIENT SIGNATURE DATE

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