

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: _____

Patient Height: _____ Weight: _____

Pharmacy Address and Phone#: _____

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: _____

Relationship to patient: _____ DOB: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Email*: _____

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:

- | | | |
|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Jaundice, Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid | <input type="checkbox"/> Y <input type="checkbox"/> N Hip or Joint Replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N COPD/Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Obstructive Sleep Apnea |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Malignancies/Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Hormonal Disorders | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Malignant Hyperthermia | <input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcer | <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N AIDS or HIV | <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain/Angina |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N TMJ (Jaw Joint) Problems |
| | | <input type="checkbox"/> Y <input type="checkbox"/> 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

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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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

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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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