Walter K. Murphy DDS

PATIENT REGISTRATION FORM — ORAL & MAXILLOFACIAL SURGERY — PAGE ONE

TODAY'S DATE mm/dd/yyyy	CHART #		SOCIAL SECURITY #	MARITAL STATUS

MR. MS. MRS. MISS	LEGAL NAME (LAST)	FIRST	MIDDLE	DATE OF BIRTH mm/dd/yyyy	SEX MALE FEMALE	EMAIL ADDRESS

ADDRESS	CITY	STATE	ZIP CODE	HOME # ( )

EMPLOYER	ADDRESS	WORK # ( )	CELL # ( )

RELATIVE (NOT AT SAME ADDRESS)	RELATIVE ADDRESS	PHONE # ( )

ENTER THE NAME AND PHONE NUMBER OF YOUR MEDICAL AND DENTAL PROVIDER(S) WHOM WE MAY THANK FOR YOUR REFERRAL TO COFS. CHECK ALL THAT MAY APPLY.

	NAME	PHONE #		NAME	PHONE#
☐ GENERAL DENTIST			☐ MEDICAL DOCTOR		
☐ ENDODONTIST			☐ FAMILY/FRIEND		
☐ ORTHODONTIST			☐ SELF		
☐ PROSTHODONTIST			☐ OTHER, PLEASE EXPLAIN		

HAVE YOU OR A FAMILY MEMBER EVER BEEN A PATIENT OF OUR PRACTICE? NO YES NAME:__________

INSURANCE INFORMATION

MEDICAL/MEDICARE COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE

SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE mm/dd/yyyy	SUBSCRIBER SOCIAL SECURITY NO.

SUBSCRIBER ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER

DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT?
YES NO

DENTAL COVERAGE

INSURANCE COMPANY NAME	ADDRESS	CITY	STATE	ZIP CODE

SUBSCRIBER NAME	SUBSCRIBER BIRTHDATE mm/dd/yyyy	SUBSCRIBER SOCIAL SECURITY NO.

SUBSCRIBER ADDRESS	CITY	STATE	ZIP CODE

EMPLOYER NAME	GROUP NUMBER	POLICY NO.	PATIENT'S RELATIONSHIP TO SUBSCRIBER

DO YOU HAVE SECONDARY INSURANCE? IF SO, WHAT?
YES NO

FINANCIAL RESPONSIBILITY

PLEASE COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS UNDER 18 OR IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR BILL

RESPONSIBLE PARTY NAME	DOB: mm/dd/yyyy	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	HOME PHONE # ( )

ADDRESS	CITY	STATE	ZIP CODE	CELL # ( )

EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	PHONE #

Final Authorization and Acknowledgement

The following authorization and acknowledgement must be signed by the patient if over eighteen (18) years of age. It must be signed by the responsible person if the patient is a minor. **Likewise, it must be signed by a legal guardian or other responsible person if the patient is over eighteen (18) years of age and not responsible for his/her own debts.**

This authorization and acknowledgement must be signed prior to treatment being rendered.

(1) I hereby authorize the release of any information relating to my insurance claims.
(2) I hereby authorize payment to the doctor of benefits otherwise payable to me, but not to exceed the charges shown.
(3) I agree to pay for the services rendered and acknowledge that I am legally liable for the services.
(4) I understand that insurance is being filed as a courtesy for me and that I am responsible for the full bill sixty days from the date insurance is filed.
(5) I agree to pay all collection agency fees/attorney fees and any filing fees, court costs or other expenses incurred if my account is referred to a collection agency or attorney for collections. Attorney fees are to be assessed at 33.33% of the balance due.

DATED:__________ SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATED:__________ SIGNATURE OF INSURED IF OTHER THAN PATIENT

PATIENT NAME DATE CHART #

HEALTH HISTORY

1. Reason for visit: ____

2. Was this due to an injury? ◯ Yes ◯ No When: Date (mm/dd/yyyy) Time : ◯◯ am/pm
   How ____ Where ____

3. Are you now, or have you ever been, under a physician(s) care during the last 5 years (other than for routine physicals, colds, etc.)? ◯ Yes ◯ No

4. Please list any and all medications you are taking, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals; or prescription medication for weight loss (diet pills): ____

5. Are you taking or have you taken Bisphosphonates (Fosamax, Acetonel, Aredia, Boniva, Zometa, and Didronel) for osteoporosis, chemotherapy for multiple myeloma, etc.? ◯ Yes ◯ No

6. List any allergies or unfavorable drug reactions:

7. Do you have any reason to believe you may be immunosuppressed (from disease, drugs, transplant surgery, etc.)? ◯ Yes ◯ No
   If yes, please explain:

8. Are you taking any medication or have you had any surgery that may have affected your immune system? ◯ Yes ◯ No
   If yes, please explain:

9. Have you experienced chronic fatigue, night sweats, chronic cough or recurrent mouth sores? ◯ Yes ◯ No
   If yes, please explain:

10. Are you currently being treated or have you ever been treated for a TMJ Disorder? ◯ Yes ◯ No
    If yes, please explain:

11. Do you smoke or chew tobacco? ◯ Yes ◯ No
    If yes, how much?

12. Have you ever had surgery? ◯ Yes ◯ No
    If yes, please explain:

13. Have you ever had IV Anesthesia? ◯ Yes ◯ No
    If yes, did you have any complications (explain):

14. Is there any family history of chronic illness or anesthetic complications? ◯ Yes ◯ No
    If yes, please explain:

15. Indicate which of the following you have had, or have at present. Please mark "Yes" or "No" to each item.

◯ Yes	◯ No	Heart (Surgery,Disease,Attack)	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis
◯ Yes	◯ No	Chest Pain	◯ Yes	◯ No	Thyroid Problems	◯ Yes	◯ No	Liver Disease
◯ Yes	◯ No	Congenital Heart Disease	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Yellow Jaundice
◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Contact lenses	◯ Yes	◯ No	Venereal Disease
◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	Cold Sores / Fever Blisters
◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Chronic Cough	◯ Yes	◯ No	Blood Transfusion
◯ Yes	◯ No	Artificial Heart Valve	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No	Hemophilia
◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Sickle Cell Disease
◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Bruise Easily
◯ Yes	◯ No	Arthritis/Rheumatism	◯ Yes	◯ No	Latex Sensitivity	◯ Yes	◯ No	Neurological Disorders
◯ Yes	◯ No	Cortisone Medicine / Steroid	◯ Yes	◯ No	Allergies or Hives	◯ Yes	◯ No	Epilepsy or Seizures
◯ Yes	◯ No	Swollen Ankles	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No	Fainting or Dizzy Spells
◯ Yes	◯ No	Stroke	◯ Yes	◯ No	Radiation Therapy	◯ Yes	◯ No	Nervous / Anxious
◯ Yes	◯ No	Artificial Joints (hip,knee,etc)	◯ Yes	◯ No	Chemotherapy	◯ Yes	◯ No	Psychiatric/Psychological Care
◯ Yes	◯ No	Kidney Trouble	◯ Yes	◯ No	Tumors			
◯ Yes	◯ No	Stomach Ulcers						

16. Do you have or have you had any disease, condition, or problem not listed? ◯ Yes ◯ No
    If yes, please list/explain:

17. Is there any other question or issue you would like to discuss with the doctor? ◯ Yes ◯ No
    If yes, please explain:

18. Women — Pregnant? ◯ Yes ◯ No — If yes, No. of months: — Nursing? ◯ Yes ◯ No — Taking birth control pills? ◯ Yes ◯ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Physician Review Date

Patient / Guardian Signature Date

WALTER K. MURPHY, D.D.S.
ORAL & MAXILLOFACIAL SURGERY

Patient Name:___________________________ **DOB**________________ **Chart #**___________________

NOTICE REGARDING HIV TESTING

Virginia Law requires that we inform you of the following:

The patient is hereby informed in accordance with Section 32.1-45.1 of Code of Virginia, 1950, as amended, that if the provision of health care service to the patient at Walter K. Murphy, DDS, P.C. directly exposes any person employed by or under the direction of Walter K. Murphy, DDS or any other health care provider, to the patient's body fluids in a manner which may transmit Human Immunodeficiency Virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such test results to the person(s) exposed. Thus required the collection of a blood sample and will be performed at the expense of Walter K. Murphy, DDS.

I certify that I have read, and fully understand, this consent for testing.

____

Patient Signature (must be 18 yrs. Old) *Print Name* *Date*

____

Patient Legal Guardian Signature *Relationship* *Date*

Patient Representatives Acknowledgement of Notification Where Patient is Unable to Sign

I __________________________ am the above-names patient's ___________________________

Name of Patient Representative *Relationship to Patient*

and on behalf of the patient hereby acknowledge that the patient has been given the foregoing notification concerning Section 32.1-45.1.

____

Representative Signature *Print Name* *Date*

AUTHORIZATION AGREEMENTS

I hereby authorize insurance payments be made to Dr. Murphy otherwise payable to me. I hereby authorize Dr. Murphy to release any information regarding my medical history, treatment, or benefits payable for this claim.

If my account is more than thirty (30) days overdue, I hereby agree to pay a billing charge of 1.5% on any outstanding balance until paid in full, unless previous financial arrangements have been made. I hereby agree to pay any and all expenses incurred in collection of my overdue account, including all court costs, collection service fees and reasonable attorney's fees.

If applicable, I request that payment of authorized Medicare benefits be made on my behalf to Dr. Murphy for any services furnished me by that provider. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

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Responsible Party *Print Name* *Date*