Fallon Oral Surgery

West Taft Medical Park, Suite 109
4820 West Taft Road
Liverpool, NY 13088
Telephone: 315-451-6988, Fax: 315-453-0150

Please review our office and payment policies and fill out the attached forms prior to your appointment. Please bring the *completed* forms to your appointment. If you have any questions, feel free to call!

Our office policy regarding insurance and payments is as follows:

We are a NON PARTICIPATING, OUT OF NETWORK PROVIDER.

If you have an insurance that we are able to bill, claims will be submitted to your carrier (for them to reimburse you what is covered) as long as you provide the billing department with proper updated information, which includes: the subscriber, the subscriber's date of birth, the carrier name, insurance ID number, and proper mailing address. **Federally funded insurances (Medicare/Advantage Plans, TriCare) cannot be submitted as we are an opt-out provider. We are unable to treat patients with State Funded plans (CHP, Fidelis, Medicaid, UHC Community, etc).** We are also opt out from Worker's Comp and No-Fault Insurance and no billing from our office or yourself are allowed.

Regardless of insurance coverage, you are expected to pay a deposit at your appointment. If you have had a consultation appointment, your deposit due will be what was told to you at that visit.

FOR ALL OTHER PATIENTS: We will collect $1000 deposit via CASH OR CREDIT CARD when you arrive. If your procedure does not cost $1000, you will get a refund for the difference before you leave. If your procedure costs more than $1000, you will have ***three months*** to pay the balance.

General Policies

All new patients will be required to show their photo ID when they check in. We will take a copy and attach it to your account. This is for your safety and for ours.

Any patients under age 18 *must* have one adult accompany them.

A referral from your general dentist is required. If the referral was given to you, please make sure it comes with you. If it was not handed to you, please make sure that we have it prior to your appointment. If we do not have your referral, your visit will be rescheduled.

Please contact the office at (315) 451-6988 with any questions regarding payment or insurance.

I understand and agree to the above policies.

_____ _____

Signature Date

PATIENT REGISTRATION FORM

I. Patient Information

Date: _____

Marital Status _Single _ Married Family Dentist_____ Family Physician_____

Title_____ Suffix_____ Sex: ___Male ___Female Date of Birth_____ Age_____

Last_____ First_____ MI___ Nickname_____

Address _____

_____

City _____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Email_____

Social Security # _____ Driver's License # _____

II. Employment Information

Patient's Employer _____ Occupation _____

Employer's Address _____

City/State/Zip _____ Phone _____

Responsible Party Name _____

Responsible Party Employer _____ Occupation _____

Employer Address _____

City/State/Zip _____

Employer Phone _____ Social Security # _____

III. Insurance Information

PRIMARY: Insurance Type __ Medical __ Dental

_____
Subscriber Name of Ins Carrier

_____
Subscriber DOB Subscriber SS#

_____
Group # Policy #

SECONDARY: Insurance Type __ Medical __ Dental

_____
Subscriber Name of Ins Carrier

_____
Subscriber DOB Subscriber SS#

_____
Group # Policy #

HIPPA CONTACT RELEASE FORM

Fallon
ORAL SURGERY AND IMPLANTOLOGY OF SYRACUSE

Name: _____ **DOB:** _____

In order to help us stay within the guidelines of HIPPA, please list below any person(s) that you authorize to disclose information to regarding your Protected Health Information, including billing information. (You do not need to list your doctors.)

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

>Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

>Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. The Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of the Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person(s): Paul T., Timothy J., Paul Casey Fallon and Kipp Slocum
Telephone: (315) 451-6988
Fax: (315) 453-0150
Address: 4820 West Taft Road, Suite 109, Liverpool, NY 13088

>Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

>Fees & Payments: Although we accept payments from your insurance company toward your account, you are responsible for your full account. I am aware that they accept MasterCard and Visa. **WE ARE A NON-PARTICIPATING PROVIDER FOR ANY INSURANCE COMPANY.** I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due it is turned over for collection. I agree to pay the collection fees based on my amount outstanding. This signature on file is my authorization for the release of my information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X **SIGNATURE OF GUARANTOR:** _____ **Date:** _____

> I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X **Signature:** _____ **Date:** _____

HEALTH QUESTIONNAIRE FORM

I. General Information

Name_____ Date: _____

Reason for today's office visit: _____

To Our patients: Although oral surgeons treat the area in and around your mouth, our mouth is part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

☐ Yes ☐ No Are you in Good Health? Height: _____ Weight: _____

☐ Yes ☐ No Have there been any changes in your general health in the last year?

_____

☐ Yes ☐ No Are you under the care of a physician? Date of last visit: _____

If YES, for what are you being treated? _____

☐ Yes ☐ No Have you had any illness, operation, or been hospitalized in the past five years>

If YES, please list: _____

Have you had or do you currently have...			
	Yes	No	Notes
Anemia	☐	☐	
Anesthetic Problems (Family History)	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding Tendency	☐	☐	
Blood Transfusion	☐	☐	
Bronchitis, Chronic Cough	☐	☐	
Cancer	☐	☐	
Cardiac Pacemaker	☐	☐	
Chemotherapy or Radiation	☐	☐	
Contact Lenses	☐	☐	
Contagious Disease	☐	☐	
Convulsions	☐	☐	
Delay in Healing	☐	☐	
Diabetes	☐	☐	
Dialysis	☐	☐	
Difficulty Breathing	☐	☐	
Emphysema	☐	☐	
Epilepsy	☐	☐	
Eye Disease	☐	☐	
Fainting Spells	☐	☐	
Gallbladder Trouble	☐	☐	
Hay Fever/Sinus Problems	☐	☐	
Heart Attack/Chest Pain	☐	☐	
Heart Disease(Family History)	☐	☐	
Heart Murmur/Artificial Valves	☐	☐	
Heart Surgery	☐	☐	

Have you had or do you currently have...			
	Yes	No	Notes
High Blood Pressure	☐	☐	
History of Drug/Alcohol Abuse	☐	☐	
Infection	☐	☐	
Irregular Heart Beat	☐	☐	
Jaundice, Hepatitis, Liver Disease	☐	☐	
Kidney Trouble	☐	☐	
Low Blood Pressure	☐	☐	
Low Blood Sugar	☐	☐	
Malignant Hyperthermia	☐	☐	
Mental Health Problems	☐	☐	
Mitral Valve Prolapse	☐	☐	
Are You Pregnant/Nursing?	☐	☐	
(estimated Due date)			
Problems with Immune System	☐	☐	
Prosthetic Knee/Hip, etc.	☐	☐	
Removable Dental Appliance	☐	☐	
Rheumatic Fever	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Smoker	☐	☐	
Sore in Mouth	☐	☐	
Stomach Ulcers	☐	☐	
Stroke	☐	☐	
Swollen Ankles	☐	☐	
Thyroid Trouble	☐	☐	
TMJ-Pain & Clicking of Jaws	☐	☐	
Tuberculosis	☐	☐	
Tumor or Growth	☐	☐	

HEALTH QUESTIONNAIRE FORM

Name_____ Date: _____

II. Allergy Information

	Yes	No	Notes
Local Anesthetic	☐	☐	
Penicillin	☐	☐	
Sodium Pentothal, Valium, or other Tranquilizers	☐	☐	
Aspirin	☐	☐	
	☐	☐	

	Yes	No	Notes
Codeine or other Narcotics	☐	☐	
Other Medications	☐	☐	
(Please List)			
Allergies other than Drug Allergies	☐	☐	
Latex Allergy	☐	☐	
Food Allergies	☐	☐	

III. Medication information

	Yes	No	Type
Birth Control	☐	☐	
Anticoagulant (Blood Thinner)	☐	☐	

List all medications, drugs, or pills:

Note to Women: Antibiotics (such as penicillin may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control

IV. Osteoporosis / Bone Strengthening Medication

☐ Yes ☐ No Have you ever taken medication (by mouth or IV) to strengthen your bones or to make them more dense? Examples include: Fosamax, Boniva, Aredia, Prolia, Actonel, and Reclast, Xgeva). If yes, please fully explain (when did you take it, what did you take, how was it administered, for how long did you take it, etc.)

V. Miscellaneous

☐ Yes ☐ No Is there any condition concerning your health that the Doctor should be made aware of?

If YES, please Explain:

☐ Yes ☐ No Is this visit Related to an Accident?

Type of Accident: _____

Date of Injury: _____

Description of Accident: _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any member of his staff, responsible for errors or omissions that I have made in the completion of this form.

X_____ _____

Patient's (or Legal Guardian's) Signature **Date:**

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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ORAL SURGERY AND IMPLANTOLOGY OF SYRACUSE

Patient's Name: _____ **Date:** _____

Please initial each paragraph after reading.

Extraction of teeth is an irreversible process, and whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

___1. Swelling and/or bruising and discomfort in the surgery area.

___2. Stretching of the corners of the mouth resulting in cracking or bruising.

___3. Possible infection requiring additional treatment.

___4. Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.

___5. Possible damage to adjacent teeth. Especially those with large fillings or caps

___6. Numbness, pain or altered sensations in the teeth, gums, lip, tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.

___7. Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exits.

___8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.

___9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

___10. Incomplete removal of tooth fragment – to avoid injury to vital structures such as nerves or sinus sometimes small root tips may be left in place.

___11. Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.

___12. Jaw fracture – while quite rare, it is possible in difficult or deeply impacted teeth.

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Teeth to be removed/Procedure:_____

Alternative treatment:_____

_____

GENERAL RISKS OF BONE GRAFTING

___1. Bleeding, swelling or infection at the donor site requiring further treatment.

___2. Allergic or other adverse reaction to drugs used during or after the procedure.

___3. The need for additional or more extensive procedures in order to obtain sufficient bone for grafting.

RISKS AND COMPLICATIONS OF GRAFTING FROM WITHIN THE MOUTH AREA

___1. Damage to adjacent teeth which may require future root canal procedures or may cause loss of those teeth.

___2. Removal of adult teeth in order to obtain sufficient bone material.

___3. Numbness or pain in the area of the donor or recipient site, or more extensive areas, which may be temporary or permanent.

___4. Penetration of the sinus or nasal cavity in the upper jaw which could result in infection or other complication requiring additional drug or surgical treatment.

ANESTHESIA:

LOCAL ANESTHESIA: (Novocain, Lidocaine, etc.) is given to block pain pathways in a localized area.

LOCAL ANESTHESIA WITH NITROUS OXIDE: Nitrous Oxide (or Laughing Gas) helps to decrease uncomfortable sensations and offers some degree of relaxation.

LOCAL INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: alters your awareness of the procedure by producing sedative/amnesiac effects or sleep.

Whichever technique you choose, the administration of any medication involves certain risks. These include:

1. Nausea and vomiting
2. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment.

In addition, there may be:

1. Pain, swelling, inflammation or infection of the area of the injection.
2. Injury to nerves or blood vessels in the area.
3. Disorientation, confusion, or prolonged drowsiness after surgery.
4. Cardiovascular or respiratory responses which may lead to heart attack, stroke or death.

Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. If you have any questions, PLEASE ASK.

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I have read and understand the above and give my consent for:

- ☐ Local Anesthesia
- ☐ Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- ☐ Local Anesthesia with Intravenous Sedation or General Anesthesia

CONSENT

I have read and understand the above and give my consent to surgery. I further state that if I have IV Sedation or General Anesthesia, that I HAVE NOT HAD ANY SOLIDS OR LIQUIDS BY MOUTH FOR **SIX (6) HOURS PRIOR TO SUGERY. TO DO OTHERWISE MAY BE LIFE-THREATENING!** I agree not to drive myself home and have a responsible adult to accompany me until I am recovered from my medications. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. I certify that I speak and write English.

X _____

Patient's (or Legal Guardian's) Signature **Date**

X _____

Doctor's Signature **Date**

X _____

Witness' Signature **Date**