A|OS
AIRLIE ORAL SURGERY
2001 S Baxter Dr
Leland, NC 28451

Welcome to Airlie Oral Surgery!

Dear Patient, at Airlie Oral Surgery, your peace of mind and safety are our top priority. We pride ourselves on our relentless pursuit of excellence, while at the same time providing a friendly practice to experience honest and thoughtful patient centered care.

The foundation of our practice is built on honesty and integrity, so that we may always focus on what's best for our patients. Whether you are in need of communication, state of the art technology, or a gentler approach to oral surgery, Airlie Oral Surgery is the practice for you.

Sincerely,

C. Craven Jameson, II, D.M.D.

And your Airlie Oral Surgery Team

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Missed Appointment/Cancellation Policy

As an oral surgical practice, our day is carefully scheduled with every effort given to proper time allotments for individualized care of each of our patients. Preparing for your surgery, supplies, equipment, and staffing can be extensive and costly. When an appointment is scheduled, that time has been set aside for you and when it is missed or rescheduled with late notice, that time cannot be used to treat another patient. Therefore, we have implemented the following policies regarding missed and cancelled appointments.

Our policy is as follows

- **A minimum of 48 hours (about 2 days) notice is required for all cancellations.** Cancellations for Tuesday appointments are required by 12:00 p.m. on the previous Friday.
- A $100 deposit will be collected for a consultation after a missed appointment to reserve your next visit. This will be added to your consultation cost the day of your next appointment.
- A $200 deposit will be collected the day you schedule your procedure or no later than two weeks prior to your surgery date. This deposit will be used towards your procedure cost the day of surgery.
- A $200 fee will be charged for all missed or all surgery appointments that are cancelled without the above 48-hour notification.
- Larger surgical cases are subject to the 48-hour notice, as well as a missed/cancellation charge totaling a percentage of the entire case. Our office will inform you regarding these cases.
- No future appointments can be scheduled without the payment of the missed appt fee.
- Our policies and procedures have been established to ensure the highest quality of patient care. Missed and late cancellations prevent others in the community from receiving much needed specialty care.

Thank you for your understanding and adherence to this policy.

_____ _____

Signature Date

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Financial Policy

We require payment for consultation fees at the time of service. Payment can be made with cash, personal check, MasterCard, Visa and Discover. We offer financing through Care Credit and Sunbit upon credit approval. We require a $200 deposit for surgical procedures with verifiable proof of insurance coverage, and $200 deposit from patients without verified insurance coverage. If the payment to our office is greater than your remaining balance due, a refund will be made to the guarantor of the account. Please note that refund checks are processed and distributed by the 5th of the month.

We realize that the timing of some major procedures may not fall at a good time for you financially, and our office makes every effort to keep down the cost of your oral surgical care. If you have insurance, as a courtesy, we will call your insurance company to help determine your benefits and provide an estimate for your payment. We will also submit your claims to the insurance company. Please provide us with the correct insurance information. If a pre-estimate is requested, please know it can take four to six weeks for the insurance company to help determine your benefits and provide us with an estimate of your payment. The insurance that you have is a contract between yourself and your insurance company. Many people have dental and/or medical insurance, please remember insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Please realize, however, that we have no control over what your insurance policy “covers” or exactly “how” much they will pay for a given procedure, even after the service has been rendered. There are many different insurance companies and plans, it is important that you understand the benefits available for your particular coverage. It is your responsibility to pay the deductible amount, co-insurance, or any other balance not paid by your insurance company including collection costs, attorney’s fees & court costs.

If your insurance company does not remit payment on your behalf within 60 days (about 2 months), the entire balance due is your responsibility. We recommend that you follow up with your insurance company to inquire about the status of your claim approximately 30 days (about 4 and a half weeks) after the claim was made.

We are providing you with this information so you will understand that you, and not your insurance company, are responsible for payment for our professional services. Regardless of insurance benefits, please be prepared to pay the entire amount. To prevent you from being surprised by the amount you will need to pay and give you the opportunity to plan and prepare your finances, please discuss your fees prior to receiving our services. It is our policy that the parent requesting treatment for a dependent is responsible for payment of services.

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I have read this “Financial Policy” and understand that payment of all fees is my responsibility

_____ _____

Responsible Party Signature Date

_____ _____

Witness Signature Date

TO INSURANCE COMPANIES:

You are hereby authorized to pay directly to Dr. Craven Jameson II, and I further authorize the doctor to give a report of my condition to you upon request in writing.

_____ _____

Responsible Party Signature Date

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Patient Information

Please complete in ink (Required*)

*Full Name_____*Date of Birth_____

*Email Address_____

*Address_____*City_____*State____*Zip Code_____

*Telephone: Home_____*Work_____ *Mobile_____

*Social Security #_____*Driver's License#_____

Occupation_____Employer_____

Gender_____Age_____Height_____Weight_____

*Emergency contact name: _____*Phone:_____

Preferred method of billing □ **By Mail** □ **Online Billing (using email address above)**

*GUARDIAN OR RESPONSIBLE PARTY

Full Name_____Relationship_____

Address_____

Home Phone_____*Work_____*Mobile_____

*INSURANCE POLICY ***PLEASE PROVIDE BOTH MEDICAL AND DENTAL INSURANCE INFORMATION***

DENTAL INSURANCE:

Name of Insured_____

Date of Birth_____ Social Security_____

Employer_____ Insurance Company_____

Address_____

Policy#_____Group#_____Phone#_____

MEDICAL INSURANCE:

Name of Insured_____

Date of Birth_____ Social Security_____

Employer_____ Insurance Company_____

Address_____

Policy#_____Group#_____Phone#_____

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HIPAA ACKNOWLEDGMENT

I _____ (printed name) acknowledge I have been provided a reference copy of the HIPAA Notice of Privacy Policy and may request a copy of said policy.

Furthermore, I understand my personal health, insurance or other personal information collected by Airlie Oral Surgery will only be used as described in the aforementioned Notice of Privacy policy.

My signature at the bottom of this page indicates I have received, read, and understand that Airlie Oral Surgery has communicated, to me, my rights under HIPAA.

_____ _____

Responsible Party Signature Date

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Medical / Dental Information Release Form
HIPAA Release Form

Patient Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

If unable to reach me on [ ] My home number [ ] My cellphone:

[ ] You may leave a detailed message.

[ ] Please leave a message asking me to call back.

[ ] _____

Patient Signature: _____ Date:_____

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HEALTH HISTORY FORM

Patient's Name _____ **Date of Birth** _____/_____/_____

Gender _____ **Height** _____ **Weight** _____ **Today's Date** _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor
Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No
If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No
If yes, please describe_____

Have you had any adverse effects from dental treatment? Yes / No
If yes, please describe_____

Date of last dental visit?_____

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor
Have there been any changes in your general health in the past year? Yes / No
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?_____
If yes, please describe_____
Name of physician_____ Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No
If yes, please describe_____

Have you ever had surgery? Yes / No
If yes, please describe_____

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HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type_____

Diagnosis date_____

Treatments_____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No
If yes, please describe_____

_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes?	Yes / No	Relationship_____		Heart disease?	Yes / No	Relationship_____	
Lung disease?	Yes / No	Relationship_____		Bleeding problems?	Yes / No	Relationship_____	
Cancer?	Yes / No	Relationship_____					

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

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HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	**Medication and dose**

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long?_____
Have you ever sought professional care or been hospitalized for:
Substance abuse Yes / No
Emotional disorders Yes / No
Alcoholism Yes / No

Do you use:
Alcohol? Yes / No If yes, how often per week?_____
Marijuana? Yes / No If yes, how often per week?_____
Recreational drugs? Yes / No If yes, how often per week?_____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, guardian Date

_____
Printed name of patient, parent, guardian/Relationship

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HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

For office staff use - HEALTH HISTORY REVIEW

Date	Comments	Doctor's Signature

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION