THE PARK
Oral & Maxillofacial Surgery

200 West 57th Street, Suite 302
New York, New York 10019
Tel: (212) 393-4639
Fax: (917) 388-2816
Email: Info@ TheParkOMS.com
www.TheParkOMS.com

PATIENT REGISTRATION

First Name _____ Last Name _____ Date of Birth _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Sex _____ Social Security # _____ E-mail _____

Person who's responsible for your account _____ SSN _____

Phone # _____ Emergency Contact _____ Phone # _____

Dentist (or Referring Specialist – Ortho, Endo, Perio) _____

Pharmacy Name _____ Phone # _____ Zip Code _____

INSURANCE INFORMATION (Please provide us with an insurance cad)

Primary Dental Ins. Company _____ Plan Name _____

Insured Name _____ Insured Relation _____ Insured SSN_____

Subscriber ID _____ Group ID _____ Claim Center Address _____

Thank you for choosing The Park Oral & Maxillofacial Surgery as your health-care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

Payment is due at the time of service – We will request that you make your payment on the date that the services are rendered. We accept cash, checks, credit cards, and debit cards. For our patients who are children, you will be required to send payment with whoever brings the child to the appointment.

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. The office, however, agrees to make reasonable efforts to work directly with your insurance to obtain all available reimbursement from the insurance(s) for the service rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. **You will be responsible for paying balance in full when a claim is still unpaid after 90 days.**

It is our office policy that all past due accounts be settled 90 days elapse from the date of service. We will send you thee notifications during this time period. If the payment is not made on this account and no resolution can be made, the account will be sent to a collection agency. However, we make every effort and do not send the accounts to collection while any insurance claims remain pending and until all effort to collect amounts remaining by the insurance are made. In the even an account turned over for collections, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. This will not be done until more than 90 days have elapsed until the services were rendered.

I hereby authorize The Park Oral & Maxillofacial Surgery to release information in the course of my examination and treatment to my other doctors and/or insurance carriers concerning me or my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to me or my dependents. I permit messages to be left on my phone and/or mobile phone concerning my appointment. I permit email correspondences regarding my medical-dental care treatment to other dentist or physician. I understand that email is not a confidential method of communication any may be intercepted by third parties or transmitted to unintended parties.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have given the opportunity to ask any questions I may have regarding this Notice.

I have read the above paragraphs and understand my financial responsibilities as outlined above. By signing below, I agree to the above stated terms and conditions.

_____ _____

Signature (Patient or Parent/Guardian if minor) Date

MEDICAL HISTORY FORM

Patient's Name: _____ DOB: _____ Today's Date: _____

Sex: _____ Height: _____ Weight _____ Medical history update _____ Initial _____

Do you have or have you ever had	Yes	No		Yes	No
Acid Reflux?	Yes	No	Heart Surgery/Heart Valve Replacement/Heart Attack?	Yes	No
Arthritis or Joint Disease?	Yes	No	Hepatitis? A / B / C	Yes	No
Asthmas?	Yes	No	High Blood Pressure?	Yes	No
Blood Transfusion?	Yes	No	Human Immunodeficiency Virus (HIV)?	Yes	No
Bleeding Disorder / Anemia / Bleeding Tendency?	Yes	No	Kidney Disease / Dialysis?	Yes	No
Cancer / Chemotheraphy / Radiation Therapy?	Yes	No	Osteoporosis / Osteopenia / Osteonecrosis?	Yes	No
Chronic Cough / Bronchitis / COPD?	Yes	No	Pain or clicking of jaws when eating?	Yes	No
Congenital Heart Disease?	Yes	No	Pregnant (may be) / Nursing?	Yes	No
Contact Lenses?	Yes	No	Prosthetic Joint (Knee, Hip, Heart Valve, pacemaker)	Yes	No
Convulsions / Epilepsy?	Yes	No	Rheumatic Fever?	Yes	No
Damaged Heart Valves /Mitral Valve Prolapse?	Yes	No	Sinus Problem?	Yes	No
Diabetes?	Yes	No	Sleep Apnea?	Yes	No
Emphysema?	Yes	No	Smoke / Tobacco Chewing?	Yes	No
Eye Disease / Glaucoma?	Yes	No	Stroke?	Yes	No
Hay Fever?	Yes	No	Thyroid Disease?	Yes	No
Heart Murmur / Irregular Heart Beat?	Yes	No	Tuberculosis?	Yes	No

MEDICATIONS: Are you using any of the following? List ALL the medications you are currently taking

Anticoagulants (blood thinners)?	Yes	No	Birth Control Pills?	Yes	No	Insulin?	Yes	No
Bisphosphonates, Antiangeogenic and/or Antiresorptive Medications for Osteoporosis, multiple myeloma or other cancers?							Yes	No

Other: _____

ALLERGIES: Are you allergic to o have you had an adverse reaction to? List any drug allergies not listed above.

Antibiotics?	Yes	No	Eggs / Yolk?	Yes	No	Penicillin / Amoxicillin?	Yes	No
Aspirin?	Yes	No	Local Anesthetics?	Yes	No	Sulfa Drugs / Sulfites?	Yes	No
Codeine / Narcotics?	Yes	No	Latex?	Yes	No	Valium?	Yes	No

Other: _____

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

_____	_____	_____
Signature of Doctor	**Signature of Patient/Parent/Guardian**	**Date**