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Welcome to Our Practice!

At ***Lehigh Valley Oral Surgery and Implant Center*** we have the highest standards of care. We feel that every patient deserves this standard. This philosophy is practically reflected in our everyday practice. We utilize only the instruments, sterile techniques, advanced imaging, and dental implants that have a long history of success. Treating our patients as if they we were treating our own family members is the ideal we strive to achieve each day. Thank you for taking the time to come in and experience our Oral Surgery difference. Prior to completing your paperwork, please take a few moments to review Notice of Privacy Practices, our office policies regarding communication, appointments, flexible payment options and insurances.

Appointments and Communication

In addition to reminding all patients of their scheduled appointments 2-3 days in advance, Dr. Chaudhry and his staff, follow-up with all patients after consultations and procedures. Please be sure to select your preferred method of contacting you. Patients are kindly asked to verbally confirm their appointment at least 48 hours prior to their appointment.

Payments

Payment for treatment is due the day services are rendered. It is our goal to assist all of our patients in obtaining the treatment they deserve. Therefore, we are pleased to offer several payment options, including Cash, Check, Credit Card, and third party financing through Care Credit, Citi Health and Lending Club patient financing. Apply for third party financing is easy and can be done online right here in the office. With approval there are several options including no interest plans. Our office manager can assist you in selecting the appropriate financial plan for your needs.

Dental Insurance

Our office participates with the following Dental Insurance PPO Plans: Aetna, Ameritas, Blue Cross Dental, Cigna, Delta Dental, Dentemax, Metlife, Guardian, The Principal Plan and United Concordia.

We are pleased to file insurance claims to all dental insurances and assist you in obtaining the maximum benefits specified in your contract. To best serve you, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to estimate your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

- Our office policy states that you are totally responsible for your bill. The estimated patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

- If your coverage changes for any reason, please notify the office immediately.

DENTAL PHOTOGRAPHY RELEASE

I hereby authorize Dr. Chaudhry or his assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

By signing this form below, you have read and understand our policies. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (print): _____

Signature: _____ Date_____
(Parent or guardian if minor)

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? _____

Whom may we thank for referring you to our practice? _____

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

What is the purpose of your visit?_____

Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

Person Responsible for Account (Complete ONLY if different from patient information above)

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Dental Insurance Information (Complete only if you do not have insurance cards to present front desk for copies)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Medical Insurance Information (complete only if you do not have insurance cards to present to front desk for copies)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____

Pharmacy information

Name: _____ Phone: _____ Zip: _____

LEHIGH VALLEY
ORAL SURGERY
& IMPLANT CENTER

Medical History

Patient Name: _____ Date of Birth: _____

Name and location of your general dentist: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____

2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____

3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____

4. Have you ever had any excessive bleeding requiring special treatment? Yes No

5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:

_____
_____
_____
_____

Have you ever had any of the following?

Arthritis	Y N	Eating Disorder	Y N	Kidney Disease	Y N
Asthma	Y N	Epilepsy/Seizures	Y N	Liver Disease	Y N
Alcoholism	Y N	Fainting	Y N	Mental Health Issues	Y N
Anemia	Y N	Glaucoma	Y N	Mitral Valve Prolapse	Y N
Artificial Joints	Y N	Hay Fever	Y N	Pacemaker	Y N
Aids/ARC/HIV	Y N	Heart Attack	Y N	Persistent Cough	Y N
Birth Defects	Y N	Heart Disease	Y N	Radiation Therapy	Y N
Blood Thinners	Y N	Heart Failure	Y N	Rheumatic Fever	Y N
Blood Transf.	Y N	Heart Problems	Y N	Stroke	Y N
Cancer	Y N	Heart Surgery	Y N	Psychiatric Care	Y N
Chemotherapy	Y N	Heart Murmur	Y N	Sinus Trouble	Y N
Chest Pains/ Angina	Y N	Hepatitis A,B,C,D	Y N	Shortness of Breath	Y N
Cold Sores	Y N	Herpes	Y N	Thyroid Disease	Y N
Dental Implants	Y N	Hives/Rashes	Y N	Tuberculosis	Y N
Dentures/Partials	Y N	High B/P	Y N	Ulcers	Y N
Diabetes	Y N	Low B/P	Y N	Smoker	Y N
Drug Dependency	Y N	Jaundice	Y N		

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Patient Name (print): _____

Signature: _____

Doctor Signature:_____