Merheb Surgical Arts

Patient Questionnaire

PATIENT INFORMATION

Patient Name(Last First Middle) _____

Preferred to be called/Nickname _____ Sex: ☐MALE ☐FEMALE

Social Security Number _____ Date of Birth _____ Age_____

Home Address_____City_____State___ Zip Code _____

E-Mail _____ ☐Yes, Send e-mails for appointment verification and special offers. ☐ No, Thanks

Home Phone_____ Work Phone _____Cell Phone _____

It is OK to contact me by*(Circle all that apply)*: HOME PHONE / WORK PHONE / CELL PHONE / MAIL / EMAIL

Marital Status *(Circle One)* SINGLE / MARRIED / DIVORCED / WIDOWED

Employment Status*(Circle One)* FULL-TIME / PART-TIME / FT STUDENT / PT STUDENT / RETIRED

Referral Information*(Circle One)* LIVES IN AREA / YELLOW PAGES / RADIO / TELEVISION / COUPON

FAMILY REFERRAL _____ FRIEND REFERRAL_____

PHYSICAN REFERRAL_____ _____ OTHER _____

Primary Care Physician_____ Dentist _____

EMPLOYMENT INFORMATION

Employer_____ Occupation _____

Student: School/College_____

Spouse/Parent Name_____ Today accompanied by _____

REASON FOR VISIT

_____

_____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN PATIENT INFO)

Name _____Relationship_____

Home Address_____City_____ State_____ Zip _____

Social Security Number_____ Date of Birth _____ Phone _____

Employer_____ Occupation_____ Business Phone _____

EMERGENCY CONTACT INFORMATION

Primary Contact_____ Phone Number_____

Address*(If different than pt)*_____City_____ Zip Code _____

Alternate Phone Number_____ Relationship to Patient_____

Secondary Contact_____ Phone Number _____

Address*(If different than pt)*_____City_____ Zip Code_____

Alternate Phone Number_____ Relationship to Patient_____

To the best of my knowledge, the forgoing questions have been accurately answered.

_____ _____ _____

Patient / Guardian Signature Date Doctor's Initials

Fitzpatrick Skin Type Quiz

Name: _____Date: _____

This information will help us to better evaluate your skin type so that your treatment will be more effective. Skin type is often categorized according to the Fitzpatrick Skin Type Scale, which ranges from very fair skin (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your physician are:

- ✧ Genetic disposition
- ✧ Reaction to sun exposure and tanning habits

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also include the color of your eyes, hair, etc. The way your skin responds to sun exposure is another way of correctly assessing your skin type. Recent tanning, whether by the sun or an artificial tanning booth, even tanning creams, can have a major impact on your skin color evaluation.

By using the information you provide on this form, we can be better prepared to provide you with the best care. Please take a few minutes to fill out this questionnaire.

Mark 0 through 4 for each question.

Genetic Disposition:

	0	1	2	3	4	Score
Your Eye Color?	Light Blue/Gray/ Green	Blue/Grey/ Green	Blue	Dark Brown	Brownish Black	
Natural Color of your hair?	Sandy/Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black	
Color of your non-exposed skin?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown	
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	
			Total Score	**For Genetic**	**Disposition:**	

Reaction to Sun exposure:

	0	1	2	3	4	Score
What happens when you stay too long in the sun?	Pain, redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes, followed by peeling	Rarely Burns	Never Burns	
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown within hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	
			Total Score	**For Sun**	**Exposure:**	

Tanning Habits:

	0	1	2	3	4	Score
When did you last expose your body to sun or tanning booth/creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than 2 weeks ago	
Did you expose the areas to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always	
			Total Score	**For Tanning**	**Habits:**	

Which of the following best describes your skin type? Please circle one.

1. Always burn, never tan.
2. Always burn, sometimes tan.
3. Sometimes burn, usually tan.
4. Rarely burn, tan.
5. Moderately pigmented skin, tan very easily.
6. Deeply pigmented skin, never burn

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

Ethnic background is of importance when considering skin color for these treatments.

If known, what is your ethnic background? _____

Summary:

_____ Total Score for Genetic Disposition
_____ Total Score for Reaction to Sun Exposure
_____ Total Score for Tanning Habits
_____ **SKIN TYPE SCORE**
_____ **FITZPATRICK SKIN TYPE**

Merkeb Surgical Arts

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Primary Physician | General Dentist | Orthodontist

Other (cardiologist, OBGYN…)_____

Y N Are you in good health?
Y N Has there been any change in your general health in the past year?
Date of last Physical Exam _____
Y N Are you now under a physician's care for a particular problem?

DO YOU HAVE OR HAVE YOU EVER HAD:

Answer the questions by circling Yes (Y) or No (N)

Y N Rheumatic Fever or Rheumatic Heart Disease
Y N Congenital Heart Disease
Y N Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart surgery, Pacemaker)
Y N Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)
Y N Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion
Y N Seizures, Convulsions, Epilepsy, Fainting or Dizziness
Y N Do you bruise easily?
Y N Liver Disease (Jaundice, Hepatitis)
Y N Kidney Disease or painful/bloody urination
Y N Diabetes
Y N Thyroid Disease (Goiter)
Y N Arthritis
Y N Stomach Ulcers or Colitis
Y N Chronic Diarrhea/Bowel Troubles
Y N Eye Problems (Glaucoma, Eye dryness)
Y N Do you wear contact Lenses?
Y N Ankle Swelling
Y N Breast Problems / Disease
Y N Skin Problems
Y N Osteoporosis
Y N Deafness or Impaired Hearing
Y N Frequent or Severe Headaches
Y N Have you ever had a bone density scan?
Y N Recent Gain or Loss in Weight?
Y N Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)
Y N Radiation (X-ray) treatment for Cancer
Y N Facial Paralysis or Numbness
Y N Limited Activity
Y N Clicking or popping of Jaw joint, main near ear, difficulty opening mouth, grind or clench teeth
Y N Sinus or Nasal Problems
Y N Vericose Veins
Y N Any Disease, drug or transplant operation that has depressed your immune system
Y N HIV or AIDS
Y N Low Back Trouble / Backache
Y N Hemorrhoids
Y N Do you smoke or chew tobacco?
How much per day?_____

ARE YOU USING ANY OF THE FOLLOWING:

Y N Aspirin or drugs such as Motrin, Aleve or Ibuprofen
Y N Antibiotics
Y N Anticoagulants (Blood Thinners)
Y N High Blood Pressure Medications
Y N Steroids (Cortisone, Prednisone, etc)
Y N Tranquilizers
Y N Insulin or Oral Anti-Diabetic Medications
Y N Digitalis, Inderal, Nitroglycerin or other heart drugs
Y N Are you taking or ***HAVE YOU EVER TAKEN*** Bisphosphonates for osteoperosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa
Y N Have you ever been advised <u>*NOT*</u> to take any medications?

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

Y N Local Anesthesia (Novicain, etc.)
Y N Penicillin or other antibiotics
Y N Sedatives, Barbiturates
Y N Aspirin or Ibuprofen
Y N Codeine or other pain killers
Y N Latex or Rubber products
Y N Metal of any kind
Y N Chemicals or jewelry (rash or sensitivity)
Y N Food Products
Y N Other allergies or reactions Please list
_____
_____
_____

Y N Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?
Y N Have you had any serious problems associated with any previous dental treatment?
Y N Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
Y N Have you or an immediate family member had any problem associated with general anesthesia?
Y N Do you wish to talk to the doctor privately about anything?
Y N ***WOMEN***-Are you pregnant or nursing or is there ***any chance*** you might be pregnant?
If you are using oral contraceptives, it is important you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birthcontrol for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult your physician for further guidance.

Have you ever had any serious illnesses, surgeries or hospitalizations? If so, describe:

_____

_____

_____

Please list any and all medications taken, including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

I understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history:

_____

_____

_____

Significant findings from questions or oral interview:

_____

_____

_____

Medical Management Considerations:

_____

_____

_____

MEDICAL UPDATE: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.

Date	Patient's Signature	Doctor's Initials
Date	Patient's Signature	Doctor's Initials

Merheb Surgical Arts

Financial Policy for Merheb Surgical Arts

It is the goal and commitment of our doctors and staff to provide you with the highest level of care available, for years to come. In this spirit, we believe it is possible to avoid miscommunications by having clear expectations and therefore have outlined the following policies regarding your patient account:

PLEASE INITIAL EACH LINE AND SIGN:

_____**PAYMENT IS DUE *IN FULL AT THE TIME OF SERVICE.***

We accept Cash, Checks, Credit and Debit Cards. NSF checks will cost the patient appropriate additional fees.

_____**IF YOU HAVE INSURANCE, WE ARE HAPPY TO SUBMIT CLAIMS TO MOST CARRIERS. Payment for deductibles and out of pocket expenses *are estimated and due at the time of service.***

1. We can only ***ESTIMATE*** what your insurance will cover. Therefore, the account holder is responsible for out of pocket expenses at the time of service **AND** all unpaid balances after insurance has either paid their portion, or determined otherwise.
2. Any balance remaining after insurance is complete, it will be due ***within 30 days***. Likewise, if an insurance company pays more than estimated, we will refund the excess paid by you or apply it to a current balance due on your account. You may also leave it on account for future use.
3. In the event that the insurance carrier makes an overpayment error, we will refund payment to them.
4. The patient is responsible to inform our office of any changes regarding their insurance provider or job status that might affect coverage or claim filing.
5. Most insurance companies require the insured's ***social security and date of birth***. If you do not wish to provide this information, we will be unable to file claims on your behalf. Therefore, payment in full will be due at the time of service.
6. Signature below will be used as ***Signature on File*** for claims submission. It may also be used for Credit Application and Debit/Credit Card payments initiated by the account holder via phone.

_____**FINANCING IS AVAILABLE *UPON APPROVAL.***

When work is needed now and low monthly payments would be more convenient, inquire about how we can assist you with low interest and interest free financing through an outside lending source.

_____**OUTSTANDING BALANCES ARE DUE WITHIN 30 DAYS OF THE STATEMENT DATE.**

_____**TO AVOID BILLING FEES AND MONTHLY FINANCE CHARGES…**

Please call our office promptly so we can facilitate a resolution to any/all of your concerns.

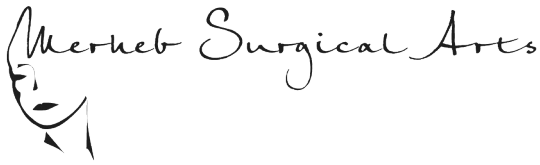
_____**MISSED APPOINTMENT FEES WILL BE CHARGED ($35.00 FEE FOR MISSED APPOINTMENTS)**

Please call our office at least 24 hours in advance to cancel or reschedule an appointment.

In the event that I fail to make payment in full (in a timely manner) or if I fail to make a reasonable payment arrangement and my account is past due, I shall be liable for and I agree to pay, all collection agency fees (not to exceed 33.3%), reasonable attorney's fees and court costs.

Patient Name _____

Patient/Guardian Signature _____ Date _____



Authorization to Discuss Protected Health Information (PHI)

Please list *any* individuals which you give permission for us to discuss your personal information with other than yourself. Our staff is unable to discuss your personal information with any individuals *NOT* listed other than yourself, your insurance providers, and other healthcare professionals.

I, _____, authorize the staff of Merheb Surgical Arts, LTD to discuss my PHI with the following individuals:

_____

_____

_____

_____

_____

The Notice of Privacy Practices

_____ **YES,** I wish to receive a copy of *The Notice of Privacy Practices*

_____ **NO,** I do not wish to receive a copy of *The Notice of Privacy Practices*

_____
Patient Name (Please Print)

_____ _____
Patient Signature/Guardian if patient under the age of 18) Date