Dr. Craig S. Sutton D.D.S.

519 West Wheatland Rd. Duncanville, TX 75116

Oral and Maxillofacial Surgery

Phone: 972-296-2921 Fax: 972-296-0277

PATIENT INFORMATION

Patient's Name (First, Middle, Last)			
Patient's Address			
City, State			Zip
Email Address			
Date of Birth	Age	Sex	SSN
Marital Status	Cell Phone		Work Phone
Are you:	Employed YES NO		Retired YES NO
Employer			
Occupation (Indicate if student and what school)			

FILL IN IF PATIENT IS A MINOR

Father or Legal Guardian	
Address if different from patient	
Phone Number	
Mother or Other Legal Guardian	
Address if different from patient	
Phone Number	

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	
Emergency Contact Phone Number	
Relation to Patient	

DENTAL INSURANCE

PRIMARY

Provider	
Name of Policy Holder	
Patient's Relationship to Policy Holder	
Policy Holder Date of Birth	Policy Holder SSN
Policy Holder Employer	
Insurance Address	
City, State	Zip
Policy Number	Certificate / ID Number
Insurance Telephone Number	

SECONDARY – IF APPLICABLE

Provider	
Name of Policy Holder	
Patient's Relationship to Policy Holder	
Policy Holder Date of Birth	Policy Holder SSN
Policy Holder Employer	
Insurance Address	
City, State	Zip
Policy Number	Certificate / ID Number
Insurance Telephone Number	

PATIENT:_____

CORE MEDICAL HISTORY

	YES	NO
1. Are you now or have you ever been under the care of of a physician during the past 5 years?	____	____
2. Do you take any medicine regularly?	____	____
3. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy?	____	____
4. Have you ever had anything breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any lung disorder?	____	____
5. Have you ever had any of the following illnesses?		

If YES, please check:

____ Heart Trouble
____ Stroke
____ Rheumatic Fever
____ Hepatitis or Liver Trouble
____ Kidney Disease
____ High or low blood pressure
____ Diabetes
____ Anemia

6. Are you subject to profuse bleeding?	____	____
7. Are you sensitive or allergic to any drugs such as aspirin, penicillin, Novocain, or codeine? **If YES, please circle.**	____	____
8. Do you have a cold or sinus trouble?	____	____
9. Have you had anything to eat or drink in the past 6 hours?	____	____
10. Do you wear contact lenses?	____	____

CURRENT MEDICATIONS TAKEN (LIST NAME AND DOSAGE):

_____

_____

_____

_____

_____

_____

Signature:_____ **Date:**_____

PATIENT RESPONSIBILITY STATEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

New patients will be required to pay for services rendered at the first visit. This will include the consultation, any radiographs and/or minor surgical fees. You will be charged the contracted rate if our office is contracted with your insurance company. **We will not accept insurance on your first visit.** Estimates for future diagnostic or surgical services will be provided at the initial consultation and quoted fees will be honored for 6 months after the consultation.

REGARDING INSURANCE

You will be responsible for providing an insurance card and/or information. We file insurance claims as a courtesy to our patients. We will file primary insurance only. It will be the responsibility of the patient to file any secondary insurance. Many companies have fixed allowances or percentages based on a contract. We can only **ESTIMATE** your portion of the surgery fee. **Your estimated amount will be due at the time your surgery is performed.** If your insurance company pays more than the balance due, we will send a refund check to you.

We will assist you in filing your insurance as much as possible. **If your insurance company has not paid the full balance within 45 days, you have 15 days to pay the balance. You are responsible for the timely payment of your account.**

DELIQUENT ACCOUNTS will be referred to collections after 60 days and subject to credit reporting. You will be responsible for the collection fees.

PAYMENT PLANS are offered through **Care Credit** for your convenience. Applications are available at the front desk. We will accept **MasterCard, Visa, American Express** and **Discover**.

My signature acknowledges that I have read this policy and understand the provisions.

_____ _____

Responsible party signature Date of Birth

Drivers license No. _____ Today's Date _____

PLEASE STOP HERE AND RETURN CHART ALONG WITH YOUR DRIVERS LICENSE AND ANY DENTAL INSURANCE CARDS YOU MAY HAVE