Palisades Oral Surgery

Name: Last , First MI		Date of Birth:	Age:	M / F
Home Address:	City, State, Zip			
Home Phone:	Cell #:		Social Security #:	
Employer name:		Email Address:		
Pharmacy name and address:				
Dentist:		Who referred you to our office:		
Dental Insurance:	Who is the insured:	Insured's SS# :	Date of birth:	relation:
Medical Insurance:	Who is the insured:	Insured's SS# :	Date of birth:	relation:

PLEASE PRESENT YOUR INSURANCE CARDS TO THE FRONT DESK

If patient is a minor, please provide parent or guardian's name:

TO OUR PATIENTS: Your answers are for our records only and will be confidential.

Are you in good health?

Have there been any changes in your general health in the past year?

Have you been hospitalized in the past 5 years: Yes No If yes, please indicate:_____

Do you have a prosthetic joint: (i.e.; hip, knee) Yes No

Rheumatic fever	Yes	No	Convulsions Epilepsy	Yes	No	Contact Lens	Yes	No
Stroke	Yes	No	High/Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	AIDS or HIV positive	Yes	No	Do you smoke marijuana	Yes	No
Thyroid Trouble	Yes	No	Sexually transmitted disease	Yes	No	Do you smoke cigarettes	Yes	No
Frequent Headaches	Yes	No	History of drug/alcohol abuse	Yes	No	Blood disorder	Yes	No
Tumor or growth	Yes	No	Hay fever (sinus problems)	Yes	No	Bruise easily	Yes	No
Kidney Problems	Yes	No	Eye disease (glaucoma)	Yes	No	Mental Health issues	Yes	No
Heart Murmur	Yes	No	Liver disease (Jaundice, hepatitis)	Yes	No	Possibility of pregnancy	Yes	No

Stomach or intestinal problems Yes No

Lung Breathing problems (ie; asthma, Emphysema) Yes No

Heart disorders (ie; Mitral valve prolapse, irregular heartbeat, heart surgery, cardiac pacemaker etc.) Yes No

Are you taking any medications? Please indicate:

_____

Do you have any allergies to medications? Please indicate:

_____

Reason for your visit today?

_____

NOTIFY IN CASE OF EMERGENCY: _____

Name Relation Telephone #

I authorize that the above history is correct to the best of my knowledge_____

Patient/Guardian Signature

TODAYS DATE_____

PALISADES ORAL SURGERY
FEES AND PAYMENTS

We make every effort to keep down the cost of our oral surgical care. You can help by paying what you are responsible for, at every visit. Other arrangements can be made with our billing manager depending upon special circumstances **prior to any appointment.** An estimate of charges for any procedure you may require will be given to you **upon your request** only. If you have any dental and/or medical insurance which we **do not participate** with, we will be glad to furnish you with the proper forms to submit to your insurance company for reimbursement.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a subsitute for payment. We **ONLY** submit insurance claims to the insurance companies in which we are participating. However, **ALL INSURANCE PLANS ARE DIFFERENT AND IT IS THE PATIENTS RESPONSIBILITY TO KNOW AND UNDERSTAND HIS/HER OWN INSURANCE PLAN**. It is ulitmately the patients responsiblity for any co-payments, deductibles and balances that are not covered by your insurance.

A 1.5% finance charge (18% annually) will be added to any balance over 30 days or minimum charge of $5.00 per month. If my delinquent account is sent to a collection agency, I agree to the addition of a collection fee of $50 or 20% of the balance owed, whichever is greater.

THERE WILL BE A $50.00 CHARGE FOR ALL BROKEN APPOINTMENTS IF WE ARE NOT NOTIFIED WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT.

This signature on file is my authorization for the doctors at Palisades Oral Surgery to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment. Furthermore, I authorize the taking of all x-rays required to process my claim. I hereby authorize payment to be paid directly to the doctor.

Signature_____ Date_____

FOR MEDICARE PATIENTS ONLY: **PLEASE READ AND SIGN:**

Medicare Number:_____

I request that payment of authorized Medicare benefits be made, on my behalf, to the doctors at Palisades Oral Surgery for any services performed by the physician. I authorize any holder of medical information pertaining to me be released to the Health Care Financing administration and its agents be given any information needed to determine these benefits payable for related services. I have been advised that if Medicare does not cover the services provided, that I will be responsible for payment in full.

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_____ _____

Beneficiary or his/her representative's signature Date

Palisades Oral Surgery
Authorization for use or disclosure of Protected Health Information

I, (name of patient) _____authorize Palisades Oral Surgery, their administrative, and clinical staff to use and/or disclose the following protected health information to my insurance company, any other treating physician, any labs and/or MRI facility if needed.

This protected health information is being used or disclosed for treatment and billing purposes.

This authorization shall be in force and effect until 7 years from todays date at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to: Peggy Cotter, Palisades Oral Surgery, The Colony, 1530 Palisade Avenue, Fort Lee, NJ 07024.

I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim or if my authorization was required for treatment provided by participating in a research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

The Notice of privacy practices was available for me to read, with the effective date of March 1, 2003.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

Palisades Oral Surgery

Vincent Carrao DDS MD FACS
Diplomate of American Board of Oral & Maxillofacial Surgery
Specialty # 5155

OFFICE PROTOCOL

The surgical operatory is one that could be intense emotionally for family members. We have had multiple incidents in the past where family members have fainted when they were present during the procedure.

Our philosophy dictates that we give 100% of our attention to the surgical patient. Furthermore, and for sanitary reasons, the surgical space needs to be maintained to the utmost sterile standards possible.

If you are being sedated, you must come to the office with a responsible adult who will stay in the waiting room **during the procedure** and drive you home. We will not release you to a cab, bus, or to walk home. It is our policy that the surgical team along with the patient **only** is present in the room **during surgery**. We have an open door policy where family members are always welcome to check back with the staff on the progress of their loved ones.

We would greatly appreciate your understanding and respect our procedure as our ultimate goal is to deliver comfortable and outstanding care to you and your loved ones.

PALISADES ORAL SURGERY

PATIENT (PARENT/GUARDIAN) **DATE**

Palisades Oral Surgery

Vincent Carrao DDS MD FACS
Diplomate of American Board of Oral & Maxillofacial Surgery
Specialty # 5155

RELEASE OF PATIENT INFORMATION AGREEMENT

Date: _____

I _____ **hereby, agree to release my personal and medical information, if needed, to the following:**

(Parents give permission if patient is a minor)

Father, Name: _____

Mother, Name: _____

Spouse, Name: _____

Other Family Member: _____

Friend, Name: _____

I wish to be contacted in the following ways:

(includes appointment confirmations)

Home #: _____

Cell #: _____

Work #: _____

Do you wish us to leave a detailed message about your appointment on your home answering machine? No other information will be given (test results, etc.)

YES_____

_____ On home answering machine _____ On cell phone

NO_____

Do not leave messages about my appointments on home answering machine

COVID-19 Pandemic Dental Treatment Consent and Release

We strive to provide a safe environment for our patients and staff, and to advance the safety of our community. However, the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. There are numerous ways in which the COVID-19 virus can be transmitted, including from surface contact, respiratory droplets and aerosols, or fine particles that travel with air currents. Dental procedures create aerosols, the amount of which depends on the type of procedure. While we are committed to providing the safest environment as possible for our patients, there can be no guarantee that our facility is completely free of the COVID-19 virus and that you will not be exposed to the virus while receiving dental treatment despite our efforts to minimize the risk of exposure.

By signing this Consent and Release in the space provided below, you hereby release, acquit, waive all claims against, and forever discharge the practice providing my treatment (the "Practice") and its owners, successors, assigns, affiliates, officers, directors, administrators, representatives, principals, agents, dentists, employees, independent contractors, insurers, and attorneys (collectively with the Practice, the "Indemnified Persons"), of and from any and all claims, charges, demands, promises, acts, agreements, costs, damages, debts, obligations, actions, causes of action (including but not limited to all avoidance actions of any type), suits in equity, expenses, executions, judgments, levies, liabilities, losses, and attorneys' fees, of whatever kind or nature, whether legal or equitable, liquidated or unliquidated, fixed or contingent, direct or indirect, suspected or unsuspected, accrued or unaccrued, known or unknown, present or future, asserted or unasserted, based upon, arising out of, appertaining to, or in connection with your exposure to the Severe Acute Respiratory Syndrome Coronavirus 2 or contracting coronavirus disease (COVID-19) as a result of or in connection with your entry into the Practice's office, receipt of dental treatment from the Practice or coming in contact with any Indemnified Person at the Practice's office, and all related costs, expenses, illness, or death you may suffer as a result.

The releases set forth and otherwise referenced herein shall be interpreted as broadly as possible and shall be completely binding and enforceable at law. You acknowledge that the releases and waivers provided for herein include all claims and/or costs, including but not limited to those you do not know or suspect to exist, and hereby waive all rights which may exist with regard to such claims and/or costs. You expressly waive the provisions of any federal, state, and local statute or regulation limiting release of unknown claims, including any statutory language stating as following: "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY, AND ANY SIMILAR LAW."

You agree that you have had the opportunity to consult with an attorney prior to executing this Consent and Release, that you voluntarily have signed the same and that you have read and understand this Consent and Release. **YOU FULLY UNDERSTAND THAT, BY SIGNING THIS CONSENT AND RELEASE, YOU ARE WAIVING IMPORTANT LEGAL RIGHTS.**

Patient:

Signature: _____ Date :_____

Print Name: _____

For Parents/Guardians: In addition to the foregoing, we/I further waive all claims against (to the same extent set forth above), and agree to hold harmless and indemnify, the Indemnified Persons and each of them, for any illness, death, costs, expenses, or other loss sustained by the Patient which results in any way from the Patient's entry into the Practice's office, receiving dental treatment, or coming in contact with any Indemnified Person at or near the Practice's office.

Parent's/Guardian's Signature (if Patient is under 18): The undersigned is a parent(s) or legal guardian(s) of the Patient and hereby consents to the foregoing Waiver of Liability and agrees (1) on behalf of the Patient for Patient to be bound by the provisions hereof, and (2) on behalf of himself or herself and each other parent or guardian of the Patient, that all of the terms hereof, including all liability waived hereby, equally apply to and they are subject to each of them.

Signature: _____ Date: _____

Print Name: _____

Coronavirus COVID-19:Patient Risk Survey

Name:_____

DOB:_____

Date:_____

Verbal Screening:

1. Have you traveled outside of the U.S. in the past 30 days? Yes No
2. To your knowledge, have you been in contact with a COVID-19 patient? Yes No
3. Are you experiencing any of the following flu-like symptoms?
   a. Shortness of breath Yes No
   b. Fever Yes No
   c. Cough Yes No

Visual Screening:

Please complete visual assessment based on your physical appearance:

- Coughing Yes No
- Sneezing/runny nose Yes No
- Pale skin Yes No
- Fatigued Yes No
- Sweating Yes No

Last edited: 3/2020