NORTHWEST
ORAL SURGEONS

5551 Winghaven Blvd., Suite 210
O'Fallon, Missouri 63368
(636) 978-NWOS (6967)

2747 W. Clay St., Suite B
St. Charles, MO 63301
(314) 291-3810

PLEASE ADHERE TO THE FOLLOWING GUIDELINES WHEN ARRIVING FOR YOUR SCHEDULED APPOINTMENT

1. All visitors are REQUIRED to wear a face mask when entering our facilities.
2. If you have x-rays, please arrange to have them sent or bring them with you the day of your appointment.
3. Bring your referral from your dentist with you.
4. Bring a list of medications and allergies to any medications the day of your appointment.
5. Bring your drivers license, medical insurance and dental insurance cards.
6. Patients under the age of 18 **MUST** be accompanied by a parent or legal guardian.
7. Have your forms **filled out and signed PRIOR to your appointment** and bring with you the day of your appointment.
8. PLEASE bring your pharmacy number and address with you the day of your appointment.
9. If you are having **GENERAL ANESTHESIA or IV SEDATION**, you must:
    a. Have nothing to eat or drink 8 hours prior to surgery (this includes water).
        i. If medications are required to be taken that day, please inform us of what medications are required the day of surgery.
    b. Bring a responsible adult to drive you home. Yor ride MUST REMAIN in the waiting area during your procedure.
    c. **We CAN NOT allow our sedated patients to take a taxi or Uber home after any sedation or General Anesthesia.**

PLEASE CONTACT OUR OFFICE IF YOU HAVE ANY ADDITIONAL QUESTIONS.

Maryann L. Udy, D.M.D
Diplomate American Board of Oral Maxofacial Surgeons
www.nworalsurgeons.com

CONFIDENTIAL MEDICAL INFORMATION

PATIENT NAME: _____
Last First MI

SEX: M/F _____ **AGE:** _____ **BIRTHDATE:** _____ **MARITAL STATUS:** S M W D

SOCIAL SECURITY # _____

STREET ADDRESS: _____
CITY _____ **STATE** _____ **ZIP** _____

HOME # _____ **CELL #** _____

GENERAL DENTIST: _____

REFERRED BY: _____
EMPLOYER/SCHOOL: _____
EMPLOYER ADDRESS: _____

IN CASE OF EMERGENCY
NAME: _____
HOME # _____ **CELL #** _____

RESPONSIBLE PARTY: _____
BIRTHDATE: _____ **RELATION:** _____
SPOUSE/PARENT/GUARDIAN
_____
Last First Middle
ADDRESS: _____
CITY _____ **STATE** _____ **ZIP** _____

SOCIAL SECURITY # _____

HOME # _____ **CELL #** _____

EMPLOYER NAME/ ADDRESS
_____

DENTAL INSURANCE: _____

MEDICAL INSURANCE:
_____

EMERGENCY CONTACT ADDRESS
_____
_____

List any Allergies to drugs or medicines, Food Allergies (Products) and Latex

_____
_____

List any Medicine, natural products, herbal supplements or teas you are taking (including all diet pills and Recreational Drugs)

SEE ATTACHED FORM

List any previous Hospitalizations/Surgeries

_____
_____

Circle any conditions that you have had

Heart Condition
Heart Murmur
Mitral Valve Prolapse
Rheumatic Fever
Artificial Heart Valve
Total Knee Replacement
Total Hip Replacement
Arterial Grafts
Other Implant Devices
Heart Surgery
_____
_____

High Blood Pressure
Lung disease
Bronchitis
Emphysema
Asthma
TB
Liver Problems
Jaundice
Hepatitis
Ulcers
Stroke
Nervous Disorders

Kidney Problems
Bladder Infections
Diabetes
Thyroid Disorder
Sickle Cell Disease
Anemia
Transfusions
Cancer
Venereal Disease
Glaucoma
Bleeding Disorder

Sleep Disorders

Yes	No	
❑	❑	Do you have chest pain?
❑	❑	Do you have shortness of breath?
❑	❑	Do your ankles swell?
❑	❑	Do you smoke? How much? _____
❑	❑	Do you have a frequent cough?
❑	❑	Do you have difficulty breathing through your nose?
❑	❑	Have you ever had hives, weakness or difficulty breathing after an injection?
❑	❑	Have you had trouble with a general anesthesia?
❑	❑	Do you bruise easily?
❑	❑	Have you had prolonged bleeding following surgery?
❑	❑	Have you had radiation (X-ray) treatment?
❑	❑	Have you had chemotherapy?
❑	❑	Have you ever taken cortisone, prednisone, or steroids?
❑	❑	Is there any unlisted health condition your doctor should know?
❑	❑	Have you eaten or drank anything in the past 6 hours?
❑	❑	Is your general health Good___ Fair___ Poor_____

PREGNANT WOMEN

Yes	No	
___	___	Are you pregnant now?
___	___	Do you anticipate becoming pregnant?
___	___	Are you breast feeding?

HEART PATIENT
Cardiologist's Name _____
Cardiologist's Phone Number _____

_____ _____
Physician Name Phone Number

PHARMACY NAME & NUMBER

_____ _____
Patient Signature Date

_____

FINANCIAL RESPONSIBILITY
NORTHWEST ORAL AND MAXILLO-FACIAL SURGEONS, INC.

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. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS WITH A DRIVERS LICENSE OR STATE ID, VISA/MASTERCARD, DISCOVER, AND AMERICAN EXPRESS. (THERE IS A 25-DOLLAR SERVICE CHARGE ON ALL RETURNED CHECKS.)**
- **OUR OFFICE ALSO HAS A MINIMUM FEE OF $100.00 TO $250.00 FOR ALL MISSED APPOINTMENTS.**

INSURANCE

With pre-approval from our office staff prior to the date of service, we may accept your estimated insurance co-payment, pending payment by your insurance carrier if your balance is over **$150.00**. If we accept your insurance co-payment, you are responsible for any estimated amount that is determined by our office to be the portion payable by you. Insurance companies will not guarantee payment on any claim until it is submitted for their review; therefore, upon receipt of payment or a denial of payment from your insurance company, we will reconcile your account for any balance due or credit payable to you. If your insurance company has not paid its portion in full with 30 days, we ask that you contact your insurance company or your employer to help expedite their review and payment on your claim. If your insurance company pays you in error, the check must be forwarded to our office within 7 days. **AFTER 30 DAYS, YOU ARE RESPONSIBLE FOR PAYMENT IN FULL IMMEDIATELY.**

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY IN MOST CASES. (If we are a contracted provider for your insurance company, we will inform you and will handle all charges according to our agreement, as it exists.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. If your account is turned over to a collection agency there may be other fees if the account is sent to an attorney. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

All pathology lab fees are the patient's responsibility. You will be receiving a separate statement from the lab for this service.

I give my permission to confer with any of my previous physicians who have treated me.

Thank you for understanding our financial policy. Please let us know if you have any questions, or concerns.

I CLEARLY UNDERSTAND IF IN DEFAULT, I WILL BE RESPONSIBLE FOR ALL LEGAL FEES TO COLLECT MY BILL. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY: PATIENT/PARENT OR LEGAL GUARDIAN **DATE**

_____ _____

SIGNATURE OF INSURED PARTY **DATE**

Patient Name :

_____

Pharmacy Name:

_____

Pharmacy Address (including city):

_____

Pharmacy Phone Number:

_____

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Patient Name:_____ Patient DOB:____/____/_____

Procedure Date:_____ Scheduled Procedure Time:_____

To help us better serve you, we will need you to provide us with a list of your current medications, including any over-the-counter medications you may be taking. **THIS INFORMATION IS VERY IMPORTANT.**

Please complete the list below and **BRING IT WITH YOU TO YOUR APPOINTMENT.**

Thank you!

	Prescription/Medication	Dosage	Frequency(how often)	Reason for Medication
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

******IF MORE SPACE IS NEEDED PLEASE CONTINUE ON BACK, OR ATTACH A SEPARATE COMPLETE LIST OF MEDICATIONS AT YOUR CONVENIENCE******

Reviewed in office by:_____ on (Date):_____

Maryann L. Udy, D.M.D.
Diplomate American Board of Oral & Maxillofacial Surgeons

Northwest Oral Surgeons

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name:_____ Patient DOB:____/____/_____

I authorize Northwest Oral Surgeons to release my medical records to:

Name:_____(Friend/Family Member/Other)

Name:_____(Friend/Family Member/Other)

AND/OR

Name:_____(Dentist/Medical Provider/Other)

Address: _____ City:_____ State: ____ Zip Code: _____

Phone:_____ Fax: _____

Email:_____

I Authorize Northwest Oral Surgeons to release my medical records to: all medical sources, including any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment, treatment or services to me or on my behalf. *Initial*:_____

I authorize the release of the following information:

- ☐ Complete Chart
- ☐ Chart notes
- ☐ X-Rays
- ☐ Discharge Summaries
- ☐ Lab Work
- ☐ Other:_____

This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

_____ ____/____/_____

Signature (Patient or Legal Guardian) Date

Northwest Oral Surgeons

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign The Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____ _____ __/__/__

Printed Name Signature Date

Insurance

I hereby authorize payment directly to Northwest Oral & Maxillofacial Surgeons.

_____ ____/____/_____

Signature (Patient or parent if minor) Date

I authorize the release of any information relating to this claim. I understand that I am responsible for all the costs of dental treatment.

_____ ____/____/_____

Signature (Patient or parent if minor) Date

*****FOR OFFICE USE ONLY*****

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, however, acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____