

Affiliates in Oral and Maxillofacial Surgery

Dr. James E. Berwick, D.D.S.

Dr. Robert C. Christiansen, D.D.S.

FINANCIAL ARRANGEMENTS

At Affiliates in Oral and Maxillofacial Surgery we make every effort to provide you with the finest surgical care and the most convenient financial options. Please note that all payments are due in full at the time of treatment unless prior arrangements have been approved. Please select one of the following payment methods that is most convenient to you.

The following Financial Options are available:

Option A: Payment in full at time of service

Payment is expected at time of treatment by:

- Cash
- Check
- Credit Card-Visa/MasterCard/Discover

Option B: Coverage by Dental or Medical Insurance

A minimum of 20% of the total surgery will be collected at the time of treatment. Please note that the 20% is an estimate of your financial responsibility. After your insurance company has made payment, the remainder of your balance is considered payable in full by you at that time. Options A (above) and C (below) are available to pay your balance.

Option C: Payment Plans/ Financial Treatment Fees or Balances

Patients wishing to finance treatment fees may be eligible for payment plans/financing through CareCredit®. CareCredit® is made available through G.E. Card Services. A minimum of \$300.00 must be financed in order to be eligible for CareCredit®. Payment terms are 3, 6, or 12 months, depending upon the amount financed. If the account balance is paid off within the agreed upon term, the financing is interest free. Failure to pay off the account balance will result in interest accruing at 22.9%.

Option D: Medicaid

I agree to the financial plan outlined above and will be responsible for payment of all fees for treatment. I will be bound by this signature that I have read and accepted all conditions listed above: — (initial). For all checks returned, there will be a \$25.00 charge plus any other costs incurred: — (initial). Checks that fail to clear will be turned over to the District Attorney's office for prosecution and recovery up to 3 times the amount of the check: — (initial).

Signature of Responsible Party

Date

MEDICAL HISTORY

Please explain any changes in your health since your last visit.

Why have you come to see Dr. Berwick today?

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MEDICAL HISTORY (continued)

Do you or have you had TMJ problems or treatment? If yes, please explain.

Do you have a personal physician? Yes No

Physician's Name and phone #:

Date of last visit: ___/___/___ Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No Explain: _____

Are you taking any prescription /over-the-counter drugs? Yes No Please list each one:

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Have you ever taken Fosamax or any other

bisphosphonate? Yes No

Have you ever taken Phen-fen? Yes No

For Women Only:

Are you using prescription birth control? Yes No

Are you pregnant? Yes No If yes, week # : ___

Are you nursing? Yes No

Date

Patient Signature

Doctor's Initials

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MEDICAL HISTORY (continued)

Have you ever had any of the following diseases or medical problems?

(Check if yes):

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Herpes / Fever Blisters |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hospitalized for Any Reason |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Artificial Bones / Joints / Valves | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer / Chemotherapy | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell Disease / Traits |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Attack / Surgery | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Venereal Disease |

Please list any other serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

(Check if yes):

- | |
|---|
| <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Jewelry / Metals |
| <input type="checkbox"/> Latex |
| <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Other |

Please list any other drugs / materials that you are allergic to:

Date

Patient Signature

Doctor's Initials