SUGAR LAND ORAL & MAXILLOFACIAL SURGERY

EDDY P. YANG, D.D.S., M.D.
15200 Southwest Freeway, Ste 360
Sugar Land, TX 77478

PATIENT INFORMATION

Please Print Clearly

USE BLACK INK

Date________________ Referred By________________________Family Dentist______________________________

Patient Home Phone______________________ Cell Phone ____________________ Work Phone__________________

Patient Name____ Circle One: Mr. Dr. Mrs. Ms. Miss

S. S.#____________________________Date of Birth__________________ Sex: ☐Male Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed Drivers License # ______________________ Issuing State______

Address_____________________________________City__________________ State________ Zip__________

Employer/Business Name__________________________________ Occupation________________________________

Employer Address_________________________________City____________________State________Zip___________

Emergency Contact Person___________________________Phone_______________ Relationship ______________

Additional Contact (not living with patient)___________________________________ Phone____________________

GUARANTOR'S INFORMATION

Guarantor's Name ____Circle One: Mr. Dr. Mrs. Ms. Miss

Home Phone_________________________ Cell Phone ______________________ Work Phone____________________

Address____________________________________City___________________ State________ Zip___________

S. S.# ____Date of Birth__________________________

Employer/Business Name__________________________________ Occupation__________________________________

Employer Address_________________________________City_____________________State________Zip___________

PARENTS' INFORMATION

Patient Lives With: ____

Father's Name____ Circle One: Mr. Dr. Mrs. Ms. Miss
☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone_______________________ Cell Phone _______________________ Work Phone___________________

Address__________________________________City______________________ State________ Zip________

S. S.# ____________________ Date of Birth ___________ Drivers License # _______________ Issuing State________

Employer/Business Name__________________________________ Occupation_____________________________

Employer Address_________________________________City____________________State________Zip__________

Mother's Name____ Circle One: Mr. Dr. Mrs. Ms. Miss
☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone_________________________ Cell Phone ______________________ Work Phone__________________

Address____________________________________City__________________ State________ Zip________

S. S.# ____________________ Date of Birth ___________ Drivers License # _______________ Issuing State________

Employer/Business Name__________________________________ Occupation_____________________________

Employer Address_________________________________City_____________________State________Zip__________

DENTAL INSURANCE

Please Provide Card For Copying

Insurance Company Name ______________________

Insurance Company Phone ______________________

Policy Holder's Name__________________________

Date of Birth ________________________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other

Street Address_______________________________

City________________ State _____ Zip_________

S.S. # __________________ Policy #___________

Group Number_______________________________

Employer ___________________________________

MEDICAL INSURANCE

Please Provide Card For Copying

Insurance Company Name_______________________

Insurance Company Phone ______________________

Policy Holder's Name__________________________

Date of Birth_________________________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Other

Street Address_______________________________

City________________ State _____ Zip_________

S.S. # __________________ Policy # ___________

Group Number_______________________________

Employer ___________________________________

Fees & Payments

We make every effort to keep down the cost of your care and an estimate of charges is provided for your planned treatment. We ask for your current medical and dental insurance information, this assists in providing you with the best estimate for your care. Every attempt is made to utilize your insurance benefits and your portion of payment is based on the information provided by your carrier. Your insurance policy is an agreement between you and the insurance company and verification of benefits is not a guarantee of payment. Ultimately the fees associated with care is the patient's responsibility and any balance that remains on the account after insurance processes your claim, or within 90 days from the date of service is due immediately. Your estimated portion is due at the time services are rendered. Insurance is not a substitute for payment owed by the patient. We base benefits off your primary insurance only, secondary insurance is filed as a courtesy and any overpayment on yours or your family account will be refunded via the method of payment used. In the case of shared custody of a child, the parent bringing the child is responsible for payment when services are rendered. Our office is not able to contact or discuss the care or attempt to collect from another party.
A $35.00 fee will be assessed for all returned checks.
You will be responsible for all collection and court costs as well as attorney fees.

Who can we discuss your treatment and financial/insurance information with?

________________________________ Relationship to patient ____________________

________________________________ Relationship to patient ____________________

I have read the above and agree to all policies above. I understand that I am responsible for all office charges. I also understand that once payment has been received from my insurance company, any balance remaining on my account will be due immediately. I authorize the release of any information necessary to process insurance claims and request payment of benefits to the provider of services.

____
Name of responsible party (please print) Relationship to patient (please print)

____
Signature of responsible party Date

____
Patient name if different than the responsible party (please print)

Implant Summary Statement

I understand that Dr. Eddy Yang will place my dental implants. The implants may not be used immediately after placement in order to allow them to integrate with the jaw bone. I understand that if the implants are immediately used after placement, there is a slight chance that the implants will not integrate with my jaw bone and possibly prematurely fail. Dr. Eddy Yang and/or staff have explained to me that he will place the implants, but he will not restore the implants after they are uncovered. I understand my dentist will also place the attachments for the crowns and/or teeth onto the implants. I also understand that my dentist will charge me to restore the implants. These charges are independent and separate from the implant surgery or placement fees. It has been explained to me that in some instances, implants fail and must be removed.
I have been informed and understand that the practice of oral surgery is not an exact science; no guarantees or assurances as to the outcome of results of treatment or surgery have been made to me. To my knowledge, I have given my dentist an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to foods, drugs, anesthetics, and other conditions pertaining to my health. I declare that I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

____
Print Name Signature Date

Sugar Land Oral and Maxillofacial Surgery, PA
Eddy Ping Yang, D.D.S., M.D.
15200 Southwest Freeway, Suite 360
Sugar Land, Texas 77479
Phone: 281-494-9433 Fax: 281-494-9435

Office Financial Policy

We welcome you as our patient and thank you for choosing Sugar Land OMS. We are committed to providing you with the finest medical/dental care at the lowest cost. We ask that you please familiarize yourself with this financial policy and feel free to present any questions or concerns so that they are resolved, and we can focus on providing you with excellent healthcare.

Insurance

PAYMENT OF CO-PAYS/DEDUCTIBLES/CO-INSURANCE ARE DUE AT THE TIME OF SERVICE. Our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. By law your insurance company must remit payment or deny your insurance claim within 30 days of initial notice. If your insurance company has not paid your account in full within 45 days, we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you.

Self-Pay

FULL PAYMENT FOR PROFESSIONAL SERVICES ARE DUE AT THE TIME OF SERVICE.
Methods of payment include cash, debit/ATM cards, Visa, MasterCard, Discover, American Express and CareCredit

Refunds

We will refund you within 30 days after the date that we determine an overpayment has been made. Please notify our billing office if you are aware of any overpayments.

Insurance Coverage Changes

Please understand that it is your responsibility to provide us with any new, updated or additional medical/dental insurance. In the event that your insurance coverage changes to a plan that we are non- participating providers, you will be responsible for payment of all fees at the time service is rendered. We can provide you with the necessary documents for reimbursement.

Financial Responsibility for Minors

Unless prior arrangements have been made, charges for minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Returned Checks

Returned checks are subject to a **$36.00 charge**. Non-payment of returned checks may be referred to the District Attorney for legal action in some cases.

Medical Records Request

There will be a **$25.00- $50.00 charge** based on Texas Medical Board rule 165.2 (tmb.state.tx.us) for every medical records request. Medical records request must be made in written form. Please allow 7 -10 business days to process medical records request.

__________ **(Patient/Responsible Party Initials)**

Sugar Land Oral and Maxillofacial Surgery, PA
Eddy Ping Yang, D.D.S., M.D.
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Insurance/Disability and/or Family Medical Leave Act (FMLA) Forms
There will be a **$25.00-$40.00 charge** (fee based on how extensive paperwork is) for completion of all Insurance/Disability and/or FMLA forms. These forms require physician review so please allow 7-10 business days for completion.

No Show Policy
Sugar Land OMS reserves the right to charge a **$45 .00 fee** for **NO SHOW** appointments or **$125.00 fee** for **Surgery appointments**. To avoid this fee, call our office to reschedule or cancel your appointment at least 48 hours before your scheduled appointment. This fee is NOT billable to your insurance company and will be your responsibility. ***To schedule a surgery appointment half of the surgery cost is due the day you schedule.***

The office realizes that there are many things that come up in people's day to day lives. While truly sympathetic, the office cannot absorb the financial responsibility of last minute cancellations. The office reserves specific times for each patient affording individual care. In fairness to all patients, this policy is in effect regardless of the reason for the cancellation.

Patients with ***Medicaid*** insurance, who missed, canceled or changed with less than 48 hours' notice more than twice will not be able to reschedule.

After Hours Calls
Dr. Yang is on call after-hours and on weekends for serious medical/dental problems or for medical/ dental emergencies. For routine medical/ dental questions or minor problems, please call during regular business hours.

As we stated above, the primary goal of our practice is to provide the finest medical/dental care and services to the people in our community. We ask that all patients pay for their examination and treatment in full on the day of each visit to our office. In regard to insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment.

I have read, understand and agree to abide by the financial policy set forth.

I also acknowledge that I have received a copy of the Sugar Land OMS, PA• Notice of Privacy Practice

______ **(Patient/Responsible Party Initials)**

_______________________________ _______________________

Signature of Patient/Responsible Party Date

Eddy P. Yang, D.D.S., M.D.
15200 Southwest Freeway Suite 360
Sugar Land, Texas 77478
Phone: 281-494-9433
Fax: 281-494-9435
Email: sugarlandsurgery@yahoo.com

Medical Necessity

In the event that your insurance company determines that a procedure/ anesthesia is not covered due to lack of *medical necessity*, the costs will be your out-of-pocket responsibility. Although medical necessity can be open for interpretation by all parties involved in your care, your insurance company will often determine that your treatment, test, or procedure may not be necessary for your health or needed to treat a diagnosed medical or dental problem. For example, your insurance company may deem that the intravenous anesthesia that you will need for surgery is not a medical necessity.

Office Policies

The person accompanying the patient is responsible for the account regardless of who carries the insurance on the patient.

We request that any person accompanying the child not leave the premises until the appointment is over, in the event a question arises regarding the child's appointment.

If you have secondary insurance, it does not necessarily mean that the combined insurance will cover your service 100%. It is up to you, the insured, to know how the two plans will coordinate benefits. THE ONLY HMO/ DMO WE ARE AFFILIATED WITH IS DELTA CARE USA (SPECIALITY FORM REQUIRED). IF YOU HAVE AN HMO/DMO, THEN YOUR INSURANCE WILL NOT PAY OUR OFFICE. I am aware that insurance will cover an estimated parentage of most dental procedures and the portion that is not covered by insurance is due at the time services are rendered.

Due to privacy policies, we do not allow cell phone or camera usage in our treatment areas. You may use your phone in the waiting areas.

Patient Name: ______________________________ DOB: ____________

____

Patient/ Guarantor Signature Date

EDDY P. YANG, D.D.S., M.D.

PHARMACY INFORMATION

Patient Name ______________________

Date of Birth ______________________

Patient E-Mail Address ______________________

Pharmacy Name ______________________

Pharmacy Street Address ______________________

City ______________ State __________ Zip __________

Pharmacy Phone (____) ______________________

Allergies to Medicine

____

____

____

____

15200 Southwest Freeway, Ste. 360 • Sugar Land, TX 77478 • 281-494-9433

HEALTH HISTORY

Patient's Name ____ Date of Birth ____ Age ____ Date ____

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

All responses are kept confidential

Y N

1. Are you in good health? ☐ ☐
2. Has there been any change in your general health in the past year? ☐ ☐
3. Date of last physical exam ____
4. Are you now under a physician's care for a particular problem? ☐ ☐
5. Have you **ever** had any serious illnesses, **operations** or **hospitalizations**? If so, describe: ☐ ☐
6. Height ____ Weight ____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ☐ ☐
   - B. Congenital Heart Disease? ☐ ☐
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ☐ ☐
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ☐ ☐
   - E. History of Sleep Apnea (OSA) ☐ ☐
   - F. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ☐ ☐
   - G. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ☐ ☐
   - H. Liver Disease (Jaundice, Hepatitis)? ☐ ☐
   - I. Kidney Disease? ☐ ☐
   - J. Diabetes? ☐ ☐
   - K. Thyroid Disease (Goiter)? ☐ ☐
   - L. Arthritis? ☐ ☐
   - M. Stomach Ulcers or Colitis? ☐ ☐
   - N. Glaucoma? ☐ ☐
   - O. Osteoporosis ☐ ☐
   - P. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ☐ ☐
   - Q. Radiation (X-ray) treatment for Cancer? ☐ ☐
   - R. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ☐ ☐
   - S. Sinus or Nasal problems? ☐ ☐
   - T. Any disease, drug or transplant operation that has depressed your immune system? ☐ ☐
   - U. Frequent or recurring mouth sores ☐ ☐
   - V. Recurrent infections of any kind ☐ ☐
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics or sulfa drugs? ☐ ☐
   - B. Anticoagulants (Blood Thinners)? ☐ ☐
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐ ☐
   - D. High Blood Pressure medications? ☐ ☐
   - E. Steroids (Cortisone, etc.)? ☐ ☐
   - F. Tranquilizers ☐ ☐
   - G. Insulin or Oral Anti-Diabetic drugs? ☐ ☐
   - H. Thyroid Medications? ☐ ☐
   - I. Marijuana or other "street" drugs ☐ ☐
   - J. Antihistamines or decongestants (seldane)? ☐ ☐
   - K Digitalis, Inderal, Nitroglycerin or other heart drug? ☐ ☐
   - L. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? ☐ ☐
   - M. **Please list** any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocaine, etc.)? ☐ ☐
   - B. Penicillin or other antibiotics? ☐ ☐
   - C. Sedatives, Barbiturates? ☐ ☐
   - D. Aspirin or Ibuprofen? ☐ ☐
   - E. Codeine or other pain killers? ☐ ☐
   - F. Latex or Rubber Products? ☐ ☐
   - G. Other allergies or reactions? Please, list ☐ ☐
10. Do you smoke or chew Tobacco? ☐ ☐
    How much per day? ____
11. Do you vape? ☐ ☐
12. Do you use alcohol? ☐ ☐
13. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ☐ ☐
14. Have you had any serious problems associated with any previous dental treatment? ☐ ☐
15. Have you or an immediate family member had any problem associated with intravenous anesthesia? ☐ ☐
16. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ☐ ☐
17. Do you wish to talk to the doctor privately about anything? ☐ ☐
18. **FOR WOMEN ONLY**
    - A. Are you Pregnant? ☐ ☐
      Date of last menstrual period ____
    - B. Are you nursing? ☐ ☐
    - C. **If you are using Oral Contraceptives**, it is important that 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 birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the 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 ____