

**George Y. Soung, DDS, FAAOMS, FACOMS**

Board Certified Oral & Maxillofacial Surgeon

\_\_Mr. \_\_Mrs. \_\_Ms. \_\_Dr. First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Male \_\_\_Female Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (IF PATIENT IS UNDER 18):**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

**PRIMARY DENTAL INSURANCE:**

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY MEDICAL INSURANCE:**

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I CERTIFY THAT I HAVE READ AND ANSWERED TRUTHFULLY TO THE ABOVE INFORMATION. I WILL NOT HOLD MY SURGEON OR ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I HAVE MADE IN COMPLETING THIS FORM.***

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name (Print):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Height: \_\_\_\_\_\_\_\_\_\_\_\_   Weight: \_\_\_\_\_\_\_\_\_\_\_\_

**Have you had or do you currently have:**

|  |  |
| --- | --- |
| Heart Condition (Irregular heartbeat, heart valve issue,previous heart surgery, etc.):  Yes / No | Describe: |
| Have you had any major illness or been hospitalized in the past 5 years:  Yes / No | Describe:   |
| Depression, anxiety, or other mental health disorder: Yes / No | Describe: |
| History of Stroke and/or Heart Attack:   Yes / No | Describe: |
| Convulsions / Epilepsy / Seizure Disorder:  Yes / No | Last Episode: |
| High Blood Pressure / Low Blood Pressure (Circle One) |  |
| Lung / Breathing Condition (Asthma, COPD, etc.):  Yes / No | Describe: |
| Tuberculosis:  Yes / No |  |
| Blood or Bleeding Disorder:  Yes / No | Describe: |
| Taking Blood Thinners:  Yes / No |  |
| Hepatitis, Jaundice, Liver disease:  Yes / No |  |
| Convulsions / Epilepsy / Seizure Disorder:  Yes / No |  |
| Thyroid Trouble:   Yes / No |  |
| Diabetes:  Yes / No  | Last HbA1c:                            Date:              |
| Kidney Condition:   Yes / No | Describe: |
| Bone Condition:   Yes / No | Describe: |
| Infectious/Contagious Diseases (HIV, Hep C):   Yes / No | Describe: |
| Cancer / Radiation Treatment:   Yes / No | Describe: |
| Reaction to anesthesia or sedation in the past: Yes / No |  |
| Previous surgeries:  Yes / No | List (with DATE):   |
| Tobacco Use:  Yes / No | Describe: |
| Alcohol Use:  Yes / No | If so, how many drinks per week:   |
| Illicit Drug Use (marijuana, cocaine, etc.):  Yes / No | If so, which one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.    How many times per week?   |

**Allergies / Medications**

|  |  |
| --- | --- |
| Please list any ALLERGIES including drugs, seasonal, food | Please list all of your current MEDICATIONS including herbal supplements (**with DOSAGES and FREQUENCY that you take them**): |
|  |  |

**I certify that I have read, and I understand the questions above.  I will not hold my surgeon or any member of his / her staff responsible for any errors or omissions that I have made in completing this form.**

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Dr. Initials: \_\_\_\_\_\_\_\_\_\_\_**



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**HIPAA OMNIBUS RULE**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION AND RELEASE INFORMATION FORM**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned acknowledges receipt of copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed and dated document shall be effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

PRINT Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative / Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any comments regarding acknowledgement or consents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like to be addressed when being summoned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ANY OTHER PERSONS WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:**

(This includes step-parents, grandparents, and any other care takers who can have access to this patient’s records)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA:

Cell Phone Work Phone Home Phone Email

I AUTHORIZE INFORMATION ABOUT MY HEALTH TO BE CONVEYED VIA:

Cell Phone Work Phone Home Phone Email

In signing this HIPAA Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This may or may not receive a third-party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your acknowledgement and consent.

**OFFICE USE ONLY:** As Privacy Officer, I attempted to obtain the patient’s (or representative’s) signature on this acknowledgement but did not because:

\_\_\_\_\_ It was emergency treatment \_\_\_\_\_ I could not communicate with the patient

\_\_\_\_\_ Patient refused to sign \_\_\_\_\_ Patient unable to sign

\_\_\_\_\_ Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s (or Representative’s) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Privacy Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**OFFICE FINANCIAL POLICY**

Insurance eligibility and benefits will be verified at the time of your initial visit. We no dot accept HMO insurance policies or any medical insurance policies. You will be responsible for any services not covered by your insurance policy. Payment of insurance benefits is not a guarantee until claim is filed and paid.

Your treatment plan will be discussed following your consultation, and before any services are rendered. We will discuss deposits and financial payment options (if applicable). If all or a part of your treatment is not covered by your insurance, the non-covered portion is due in full prior to your treatment being completed.

A pre-determination of benefits may be filed at your request to your insurance company. This may take 2-6 weeks (if not longer) for a reply. Please understand, pre-treatment estimates are still estimates, and we cannot guarantee payment will be made by your insurance company. Waverly Dental cannot be held liable for any non-payment by your insurance company.

Insurance companies that we are not in contract with will reimburse the patient directly for services. In these cases, we will collect payment in full at the time of service and will file your claim on your behalf as a courtesy.

A deposit / down payment is required for you to schedule your surgery.

As a courtesy, Waverly Dental will file all claims to your dental insurance on your behalf. It is your responsibility to follow up with your insurance company regarding payments not received in 60 days. Payment is due within 60 days of the date of service. You will receive statements as a reminder to follow up with your insurance company.

In the event of an overpayment, a refund will be issued to the patient or guarantor.

I have read and understand the terms of this policy.

Patient / Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



11840 Southmore Drive

Suite 150 Charlotte, NC 28277

P: 704-246-6051 F:704-246-6967

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**PHARMACY INFORMATION**

Any post-operative prescriptions that you need will be ELECTRONICALLY prescribed/transmitted for you.

**We will need the correct and complete pharmacy information in order to do this for you.**

Please provide the following:

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please write down COMPLETE PHARMACY ADDRESS to guarantee we have the correct pharmacy)**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest the information given is correct to the best of my knowledge and I authorize Waverly Oral Surgery to send my prescriptions to the pharmacy listed above.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**NOTICE OF CANCELLATION POLICY**

It is important when you schedule your surgery that you keep your appointment.

**Dr. Soung is very particular about running ON TIME for surgery**. Patients that arrive late for their scheduled procedure negatively impact our ability to deliver timely and efficient care to all subsequent patients on our schedule. If you are late, you may be asked to reschedule your appointment (at the discretion of Dr. Soung and his staff). If so, that appointment can be rescheduled ONE time, and the patient will be required to leave a deposit in order to book their next appointment.

**CANCELLATIONS:**

If you must cancel your appointment, we REQUIRE that you give us a **MINIMUM 48-hour (i.e., 2 business days)** notice.

Appointments that are cancelled with less than 48 hours’ notice will be counted as a missed appointment, and **YOU COULD BE SUBJECT TO A CANCELLATION/INCONVENIENCE FEE (at the discretion of Dr. Soung and/or his office manager)**.

After 2 “short-notice” cancellations, you will be dismissed from Dr. Soung’s practice and care.

**CONFIRMATIONS:**

You will be contacted via phone call and/or text message 48-72 hours prior to your surgery appointment at the number you listed on your paperwork, however it is the patient’s responsibility to know the time/date already.

We require verbal confirmation within 48 hours of your appointment.

**If we do not have verbal confirmation, the appointment might be at risk of being cancelled.**

**Payment is due at the time of surgery or consult (if that is the case) and will be collected upon arrival.**

I have read and understand the above notice on cancellations and acknowledge that if I do not confirm my surgical appointment, it will be removed from the schedule.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient / Parent / Guardian Signature Date