ADVANCED AESTHETIC CENTER FOR ORAL AND MAXILLOFACIALSURGERY

MARCOS DÍAZ, DDS

WELCOME

THANK YOU FOR CHOOSING THE ADVANCED AESTHETIC CENTER FOR ORAL AND MAXILLOFACIAL SURGERY, THE OFFICE OF DR. MARCOS DÍAZ FOR YOUR SURGICAL NEEDS. WE ARE PLEASED TO WELCOME YOU TO OUR OFFICE. ENCLOSED ARE OUR HEALTH HISTORY QUESTIONNAIRE AND THE OFFICE FINANCIAL POLICY FORMS FOR YOU TO COMPLETE AT YOUR CONVENIENCE. PLEASE BRING ALL THESE FORMS FILLED OUT WITH YOU TO YOUR APPOINTMENT ALONG WITH ANY X-RAYS, YOUR LIST OF MEDICATIONS AND/OR ANY SUPPLEMENTS YOU MIGHT BE TAKING, DENTAL AND MEDICAL INSURANCE CARDS, AND/OR REFERRAL SLIPS FROM YOUR DOCTOR. YOUR SCHEDULED APPOINTMENT DATE AND TIME IS LISTED BELOW.

OUR OFFICE PROVIDES EXCEPTIONAL CARE IN ALL FACETS OF ORAL AND MAXILLOFACIAL SURGERY IN A CLEAN, COMFORTABLE AND SAFE ENVIRONMENT. OUR SERVICES INCLUDE DENTAL AND FACIAL IMPLANTS, ANESTHESIA, COSMETIC AND LASER SURGERY, PATHOLOGY, TRAUMA AND RECONSTRUCTIVE SURGERY, CORRECTIVE JAW SURGERY, TMJ SURGERY AND DENTAL EXTRACTIONS.

WE ALSO WELCOME THE OPPORTUNITY TO MEET THE ORAL AND MAXILLOFACIAL SURGICAL NEEDS OF OTHER MEMBERS OF YOUR FAMILY OR FRIENDS, AND HOPE YOU WILL LET US KNOW IF WE CAN BE OF ANY FURTHER ASSISTANCE.

WE LOOK FORWARD TO MEET YOU SOON. PLEASE CONTACT OUR OFFICE AT ANY TIME PRIOR TO YOUR APPOINTMENT IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE FROM OUR STAFF; WE WILL BE GLAD TO HELP YOU!

THANK YOU FROM THE DOCTORS AND STAFF OF
ADVANCED AESTHETIC CENTER FOR ORAL AND MAXILLOFACIAL SURGERY

YOUR APPOINTMENT DATE AND TIME IS ON _____ .

2239 N. COMMERCE PARKWAY, SUITE 2, WESTON, FLORIDA 33326-3249
TEL: (954) 659-9990 FAX: (954) 659-9991 E-MAIL: OFFICE@FACIALSURG.CC WEBSITE: WWW.FACIALSURG.CC

ADVANCED AESTHETIC CENTER
FOR ORAL AND MAXILLOFACIAL SURGERY

General Health Questionnaire

Date: _____

Patient's Name_____ Date of Birth: _____Age_____ M ___ F ____

Home Address:_____

City: _____ State: _____ Zip: _____

Cellular Phone No. _____ Home Phone No. _____

Email: _____ If Child, Parent's Name(s): _____

Patient's Social Security No: _____ Driver's License No. _____

❒ Single ❒ Married ❒ Divorced ❒ Widowed Spouse's Name: _____

Patient/Parent(s) Employed By: _____ Business Phone No. _____

Business Address:_____ Occupation: _____

Have you ever been a patient of ours before? ❒ Yes ❒ No If so, when? _____

Reason for your visit today: (Chief Concern/Complaint): _____

Who may we thank for referring you? _____

Patient's Physician is: _____ Telephone No. _____

Patient's Dentist is: _____ Telephone No. _____

The following medical information is for your general welfare, whether you are here for a diagnostic consultation or any surgical procedure. Your general health may have a significant affect on your current condition and on the outcome of any proposed treatment.

Please Answer All Questions!

Have You Ever Had:

Yes	No	
❒	❒	Heart Murmur/Abnormal Heart Sound
❒	❒	Irregular Heart Beat
❒	❒	Rheumatic Fever/Rheumatic Heart Disease
❒	❒	Heart Disease/Heart Attack
❒	❒	Heart Surgery/Heart Valve Surgery
❒	❒	Lung Trouble/Tuberculosis/PPD (+)
❒	❒	Asthma/Bronchitis/Pneumonia
❒	❒	Snoring/Sleep Apnea
❒	❒	Shortness of Breath
❒	❒	Swelling of Ankles
❒	❒	Anemia/Sickle Cell Disease/Trait
❒	❒	High or Low Blood Pressure (Hyper - Hypo)
❒	❒	Bleeding Problems/Bleed or Bruise Easily
❒	❒	Cerebrovascular Disease (Stroke/TIA)
❒	❒	Convulsions/Seizures/Epilepsy
❒	❒	Neurologic Disorder
❒	❒	Dizziness/Fainting
❒	❒	Prosthetic Joint Replacement (Artificial)
❒	❒	Jaundice or Liver Disease/Hepatitis A B C
❒	❒	Diabetes/Hypoglycemia
❒	❒	Thyroid Disease/Nodules/Hypo - Hyper
❒	❒	A.C.T.H./Cortisone/Steroids
❒	❒	Tranfusion of Blood and Other Products
❒	❒	Unable to Donate Blood
❒	❒	Arthritis/Osteopenia/Osteoporosis
❒	❒	Painful Joints
❒	❒	Pain in Chest
❒	❒	Pain in Arms
❒	❒	Skin/Dermatological Problems/Infections

Yes	No	
❒	❒	Kidney Disease/Urinary Tract Infections
❒	❒	Ulcers/Reflux/GERD/Gastrointenstinal Issues
❒	❒	Sinus Problems/Infections/Congestion
❒	❒	Glaucoma/Eye Problems/Vision Loss
❒	❒	Tumor or Cancer
❒	❒	Radiation or Chemotherapy Treatment
❒	❒	Immune System Compromise/Frequent Infections
❒	❒	Anxiety or Depression
❒	❒	Psychiatric Illness Requiring Treatment by a Psychiatrist or Psychologist
❒	❒	Surgeries/Procedures - Dates:_____

_____

_____

_____

Have You Ever Had Allergies to:

Yes	No	
❒	❒	Penicillin - Amoxicillin
❒	❒	Aspirin - Antiinflammatories
❒	❒	Codeine – Hydrocodone (Vicodin®)
❒	❒	Iodine ❒ Topical ❒ Intravenous (IV)
❒	❒	Anesthetics (e.g. Novocaine®, etc.)
❒	❒	Latex
❒	❒	Other Medicines-Drugs: _____
❒	❒	Any Foods:_____

Female Patients:

Are you taking birth control pills? ❒ Yes ❒ No

Are you, or could you be, pregnant? ❒ Yes ❒ No

Are you currently breast feeding? ❒ Yes ❒ No

Are you now under the active care of a physician or specialist (cardiologist/hematologist, etc.) for any reason? ❒ Yes ❒ No If yes, please explain: _____

_____

_____

_When was your last physical exam? _____ Was anything unusual or abnormal found? ❒ Yes ❒ No

If yes, please explain: _____

Are there any other medical conditions of which we should be aware? ❒ Yes ❒ No

If yes, please explain: _____

_____

_Please LIST ALL MEDICATIONS you are taking including prescription medications, vitamins, minerals, supplements, over-the-counter medications, herbal/homeopathic/holistic/naturopathic:_____

_____

_____

Are you taking diet pills at this time? ❒Yes ❒ No If yes, please list: _____

Have you ever taken or are you taking prescription medication for osteopenia or osteoporosis?

❒ No ❒ Yes If "YES", have you taken or are you taking any of these drugs listed below?

❒ Actonel® (Risendronate) ❒ Didronel® (Etidronate) ❒ Boniva® (Ibandronate) ❒ Reclast® (Zoledronic acid)

❒ Fosamax® (Alendronate) ❒ Skelid® (Tiludronate) ❒ Prolia® (Denosumab) ❒ XGeva® (Denosumab)

How long ago did you start taking this medication and for how long did you take them? _____

Have you ever taken or are you taking intravenous (IV) medication for breast cancer, multiple myeloma, hypercalcemia of malignancy or Osteogenesis Imperfecta?

❒ No ❒ Yes If "YES", have you taken or are you receving any of these drugs listed below?

❒ Aredia®(Pamidronate) ❒ Zometa®(Zoledronic acid) ❒ Reclast®(Zoledronic acid) ❒ XGeva®/Prolia®(Denosumab)

How long ago did you start taking this medication ? _____

Do you smoke? ❒ Yes ❒ No If yes, how much? _____ Do you smoke marijuana? ❒ Yes ❒ No

Do you drink alcoholic beverages? ❒ Yes ❒ No If yes, how much? _____

Do you have a cold or cough at this time? ❒ Yes ❒ No

How much do you weigh? _____ ❒ Lbs. or ❒ Kg. Do you wear contact lenses? ❒ Yes ❒ No

Have you had general anesthesia before? ❒ Yes ❒ No Any difficulties? _____

Have you or a member of your family ever had difficulty with, or a bad reaction to, general anesthesia?

❒ Yes ❒ No If Yes, please explain: _____

If the patient expects to have a general anesthetic, IV sedation, or nitrous oxide analgesia at this visit, please complete the following: Who will be driving you home? _____

How long ago did you have ANY food or liquid? _____

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT:

_____ _____ _____

Patient's Signature Date Parent/Guardian Signature (if minor)

DOCTOR'S REVIEW: _____ _____

Signature Date

CONSENT FOR EXAMINATION AND X-RAYS AND AUTHORIZATION FOR RELEASE

I authorize Dr. Marcos Díaz to perform an oral and maxillofacial examination and to the taking of all the X-Rays required as a necessary part of this examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the release of any information acquired in the course of my examination or treatment to other treating doctors and/or insurance companies associated with my treatment.

Signature of Authorized Person: _____ Date: _____

OFFICE FINANCIAL POLICIES

This form has to be read and signed by the responsible billing party

We will be sure to discuss the estimated fees prior to the beginning of your treatment. PAYMENT OF FEES FOR SERVICES RENDERED IS EXPECTED AT THE TIME SERVICES ARE PROVIDED. We Accept: CASH, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. NO CHECKS ARE ACCEPTED. Please ask us about finance companies that we work with if you are interested in payment plans.

Since our profession is based on an appointment schedule, our policy is to charge for missed appointments. **If your consult appointment is not cancelled 48 hrs. (WORKING DAYS) in advance a charge of $40.00 OR MORE will be applied to your account. A non-refundable amount of $100 or HIGHER will be collected prior to be able to schedule any surgery .**

INSURANCE (There is absolutely no warranty of payment by any insurance.)

We file insurance as a **courtesy** for our patients. We will accept assignment of insurance benefits for certain procedures. However, we do require co-payments to be paid at the time of service. We do not accept any medical insurances. Any remaining balance or non-covered expense is the responsibility of the responsible billing party.

COLLECTION OF PAYMENTS

RESPONSIBLE BILLING PARTY INFORMATION

(not necessarily the insured or the patient, whoever is responsible for payments at time of service. All balances or refunds will be sent to this person):

❒ Self ❒ Spouse ❒ Mother ❒ Father ❒ Other: _____

Name: _____DOB_____Soc. Sec. No._____

Home Tel: _____ Work No. _____Cell No._____

Home Address: _____

City_____ State _____ Zip_____ Driver's License # _____

Employer: _____

Employer Address:_____

I understand that I am responsible for any fees/collection agency fees or legal fees that AACOMS will incur for the full collection of payments.

I have read the FINANCIAL POLICY. I understand and agree to every aspect of this office financial policy.

Date:_____ **Signature: _____**

(Person that signs has to be the person listed above)

INSURANCE INFORMATION: (There is absolutely no warranty of payment by any insurance, information we get is what is given over the telephone.) Please give both your DENTAL and MEDICAL insurance card(s) to the receptionist to copy.

MEDICARE PATIENTS:

****We do not accept Medicare**. PLEASE LET US KNOW IF YOU HAVE MEDICARE BEFORE YOU SEE THE DOCTOR.**

INSURED INFORMATION:

(Information of the main subscriber to the insurance)

❒ Dental ❒ Medical

Self Spouse Mother Father Other _____

Name: _____ Soc. Sec No. _____DOB_____

Home Tel: _____ Work No._____ Cell No._____

Address: _____

City_____ State_____ Zip_____ Driver's License # _____

Employer: _____

Insurance Company: _____ Ins Phone#_____

Policy No._____Group No. _____Group Name: _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize ADVANCED AESTHETIC CENTER FOR ORAL & MAXILLOFACIAL SURGERY to furnish information to _____ Insurance Company concerning my care. I further hereby assign all payments for medical/dental services rendered to me, or my dependents, by the above insurance company to be paid directly to AACOMS. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits.

Date: _____ Signature: _____

**Your estimated payment of fees are expected at the time services are rendered. If there are any balances after your insurance has paid we will only send two statements (no calls) of any balance not paid by your insurance during the following 30 days. If not paid by the due date the account will be automatically put in collections and we will add a minimum of 30% of the balance due to the balance for the collection agency fees.

Int. _____

A 1½% per month (18% annual rate) finance charge will be applied to all outstanding accounts on any remaining balance not paid by the insurance starting 30 days after services have been rendered.

Int. _____

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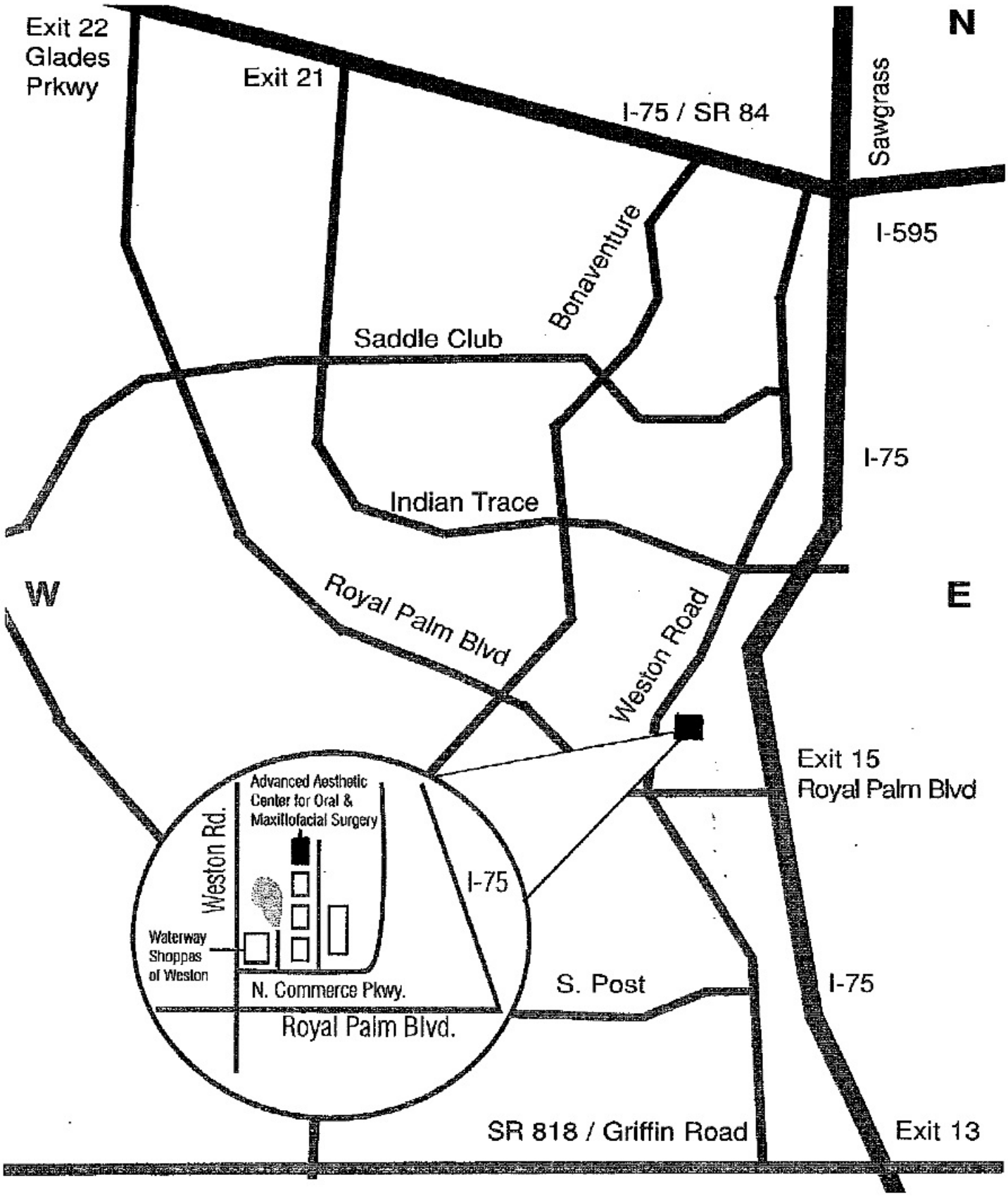
CANCELLATION POLICY

A $40.00 fee will be assessed for any appointment not cancelled within 48 hrs. (working days - Monday through Friday) of your scheduled appointment. If your consult or surgery is on Monday, we need to hear from you by the previous Thursday to prevent the cancellation fee assessment. We ask that you please speak with somebody at our office in order to ensure that the cancellation is properly processed. We will not accept messages left on the answering service or through the on-call operator as cancellations.

In addition, a non-refundable deposit fee starting at $100.00 will be charged for all surgical procedures. We will inform you of this charge at the time of scheduling your surgical appointment. There will be no reasons or excuses accepted for cancellations unless extenuating circumstances occur. It will be up to the doctor to make the final decision regarding this matter.

I _____ clearly understand and accept
Patient's name (Legal guardian)
these policies.

_____ _____
Patient's Signature (Legal guardian) Date


Exit 22
Glades
Prkwy
Exit 21
I-75 / SR 84
N
Sawgrass
I-595
Bonaventure
Saddle Club
I-75
Indian Trace
W
Royal Palm Blvd
Weston Road
E
Exit 15
Royal Palm Blvd
Advanced Aesthetic
Center for Oral &
Maxillofacial Surgery
Weston Rd.
I-75
Waterway
Shoppes
of Weston
N. Commerce Pkwy.
S. Post
I-75
Royal Palm Blvd.
SR 818 / Griffin Road
Exit 13