BELLAIRE
FACIAL, ORAL &
DENTAL IMPLANT SURGERY

Phillip T. Iero, DDS, MD, FACS

Patient Information

Patient Name: _____ Date: _____
FIRST NAME M.I. LAST NAME

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Patient Referred By: _____ General Dentist: _____

Family Physician: _____ Marital Status: ☐ Single ☐ Married

Spouse's Name: _____
FIRST NAME LAST NAME

Email: _____ Emergency Contact: _____

Emergency Contact Phone: _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account: _____ Relation to Patient: _____
FIRST NAME LAST NAME

Address of Responsible Party: _____ City: _____

State: _____ Zip: _____ Employer: _____

Address: _____ Phone: _____

MEDICARE PATIENTS: DR. IERO IS NOT A MEDICARE PROVIDER. YOUR SERVICES RENDERED IN OUR OFFICE ARE NOT BILLABLE TO MEDICARE.

PRIMARY DENTAL INSURANCE

Insurance Co.: _____

ID #: _____

Policyholder: _____
FIRST NAME LAST NAME

Relationship to Patient: _____

Policyholder S.S. #: _____

Date of Birth: _____

Employer/Group #: _____
EMPLOYER GROUP #

Insurance Address: _____
STREET

_____
CITY STATE ZIP

Insurance Phone #: _____

PRIMARY MEDICAL INSURANCE

Insurance Co.: _____

ID #: _____

Policyholder: _____
FIRST NAME LAST NAME

Relationship to Patient: _____

Policyholder S.S. #: _____

Date of Birth: _____

Employer/Group #: _____
EMPLOYER GROUP #

Insurance Address: _____
STREET

_____
CITY STATE ZIP

Insurance Phone #: _____

I (We), the undersigned, hereby agree to pay all amounts and charges incurred by myself and members of my family for services rendered by Dr. Phillip T. Iero according to the financial policies established.

In the event that Dr. Phillip T. Iero agrees to file insurance claims for myself or my family, I authorize the release of any medical information necessary to process that claim and request that payment of benefits be made to Dr. Phillip T. Iero. I further agree to pay any amount not covered by my insurance company.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

PLEASE COMPLETE MEDICAL INFORMATION ON THE NEXT PAGE

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Medical History

Patient Name: _____

Age: _____ **Weight:** _____ **Height:** _____

Please answer the following questions regarding your medical history. All answers are kept confidential.

- Are you currently under the care of a physician? ☐ Yes ☐ No
- Have you had an adverse effect from dental treatment? ☐ Yes ☐ No
- Have you had or do you currently have cancer? ☐ Yes ☐ No
  If so, please specify: _____
- Have you had complications from anesthesia? ☐ Yes ☐ No
- Do you wear contacts? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No
  If so, how often? _____
- Do you consume alcohol? ☐ Yes ☐ No
  If so, how often? _____
- Have you ever sought professional treatment for drug abuse, alcoholism, or emotional disorders? ☐ Yes ☐ No
- Do you have or have you ever had any of the following?

☐ Rheumatic Fever	☐ Asthma	☐ Blood Transfusion	☐ Frequent Mouth Sores
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Liver Disease	☐ Implants Placed **(knee, hip, heart valve, dental)?**
☐ Heart Problems	☐ Shortness of Breath	☐ Hepatitis	
☐ Heart Attack	☐ Chronic Cough	☐ Kidney Disease	☐ Radiation Treatment
☐ Heart Murmur	☐ Sleep Apnea	☐ Diabetes	☐ Grinding of Teeth
☐ Stroke	☐ Chest Pain	☐ Thyroid Disease	☐ Sinus Problems
☐ High Blood Pressure	☐ Seizures	☐ Arthritis	☐ Immune Suppressing Disease **(HIV/AIDS)**
☐ Heart Surgery	☐ Anemia	☐ Stomach Ulcers or Colitis	
☐ Pacemaker Installed	☐ Bleeding Tendency	☐ Glaucoma	☐ Recurring Infections

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No

- Do you have any other disease or condition that was not listed? ☐ Yes ☐ No
  If so, please explain: _____
  _____
  _____
- Have you ever had surgery? ☐ Yes ☐ No
  If so, list the type of surgery and the year: _____
  _____
  _____

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Medication List

To assist with providing you the best treatment possible, it is important that we have a thorough medical history. Please answer the questions below and list all of the medications you currently take (prescribed and/or over-the-counter). Notify the receptionist if you already have a medication list that we can make a copy of. If you do not take any medications, please write "NONE" in the chart.

Patient Name: _____ Date: _____

- Are you currently taking any type of blood thinners regularly (prescription, aspirin, ibuprofen, etc.)? ... ☐ Yes ☐ No
- Are you taking a bisphosphonate medication to prevent osteoporosis (e.g., Fosamax®, Actonel®, Boniva®, etc.)? ..... ☐ Yes ☐ No
- **Women:** Are you currently taking an oral contraceptive (i.e., birth control)? ..... ☐ Yes ☐ No
- Are you allergic to any medications? ..... ☐ Yes ☐ No

  If so, please list: _____

MEDICATION/DRUG NAME	HOW OFTEN DO YOU TAKE THIS MEDICATION?	WHAT DO YOU TAKE THIS MEDICATION FOR?

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Financial & Scheduling Policies

We are committed to providing the finest, most comprehensive care available today. In order for us to achieve this goal, it is important that you understand our financial and scheduling policies.

1. Payment for all services is due at the time services are rendered.
   There is a fee for today's consultation and examination. If you have insurance, we will be happy to file for you, but know that the portion not covered is your responsibility. Your surgery treatment plan and cost will be presented to you immediately following your consultation with Dr. Iero.

2. We accept the following forms of payment:
   - Cash
   - All major credit cards
   - Cashier's checks
   - CareCredit

3. We will accept benefits from your insurance carrier and file your claims as a courtesy to you. Please note that if our office is not contracted with your insurance carrier, we will only accept out-of-network assignments. It is important to remember that the information we receive from your insurance carrier is only an estimate of benefits, and we cannot be responsible for any discrepancies in benefits reported. Any unpaid balances from insurance after 60 days will become the patient's responsibility.

4. A 10% nonrefundable down payment is due to schedule surgery.

5. Surgery cancellations and reschedules must be made at least five business days prior to the original surgery date. Failing to do so could result in a charge equal to 10% of total surgical fees in addition to the nonrefundable deposit.

6. Your surgery will be scheduled to allow proper time for the procedure and recovery. If you decide to alter the originally agreed-upon treatment plan, you must notify our office 72 hours prior to surgery to allow us to make rearrangements in our schedule. Failing to do so will result in a 10% fee of the original treatment plan in addition to the nonrefundable deposit.

7. Please arrive no later than the confirmed appointment time. If you see that you will be late, it is your responsibility to contact our office immediately to avoid cancellation or delay of your surgery.

_____

Signature (Patient/Responsible Party) **Date:**

Release of Information

I hereby authorize Bellaire Facial, Oral & Dental Implant Surgery to furnish information concerning any treatment rendered to me to my insurance carrier, to any physician who referred me to Bellaire Facial, Oral & Dental Implant Surgery, and to any medical practitioner or dentist that the Bellaire Facial, Oral & Dental Implant Surgery physician may refer me to for further medical or therapy treatment. This authorization remains in effect unless revoked by me in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

Bellaire Facial, Oral & Dental Implant Surgery reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Bellaire Facial, Oral & Dental Implant Surgery.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____
(Required if patient is a minor or adult that is unable to sign this form)

Relationship of Patient Representative to Patient: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Options: Your health information may be used as necessary to support the day-to-day activities and management of Bellaire Facial, Oral & Dental Implant Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Requiring Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: Your healthcare information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:
You have certain rights under the federal privacy standards. These include

- The right to request on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Bellaire Facial, Oral & Dental Implant Surgery Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Notice of Privacy Practices

Right to Revise Policy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You have the right to inspect or copy the protected health information that we maintain, permitted by federal regulation. We require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Practice Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Front Desk
Bellaire Facial, Oral & Dental Implant Surgery
6800 West Loop South, Suite 350
Bellaire, TX 77401

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Front Desk
Bellaire Facial, Oral & Dental Implant Surgery
6800 West Loop South, Suite 350
Bellaire, TX 77401
(713) 665-9200