Gilbert T.Selkin MD, DMD
5026 Tennyson Parkway
Plano, TX 75024
Phone 972-985-1920
Fax 972-985-1176

# We are pleased to welcome you to our practice!

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at 972-985-1176 prior to your appointment, or bring the completed original forms with you to your appointment along with the other items requested below.

We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most up to date information and treatment options regarding your oral and skin care health. We do appreciate and value the trust you have placed in us.

We provide our patients and their families with full-service, comprehensive oral and maxillofacial surgery. We desire to assist you in receiving the best of what today's medicine has to offer. We are highly committed to quality patient care with an emphasis on individual attention for each patient. Providing the best service, in a comfortable, private atmosphere is extremely important to us. We assure you, we will do our best to give you total satisfaction.

We value highly the relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences at our practice. Your feedback matters because it helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

Warmest Regards,

Gilbert T. Selkin MD, DMD.

**REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT**

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

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**How did you find us?**

☐Family/Friend - Name: _____
☐Insurance Provider List
☐Internet Search
☐Newspaper Ad
☐Physician - Name: _____
☐Yellow Pages
☐Other_____

## PATIENT INFORMATION

Patient (Child) Name: _____

Guardian #1 Name: _____

Guardian #2 Name: _____

Home Address: _____
(No PO boxes)

City: _____

State: _____ Zip Code: _____

Number for appointment reminders and test results: (_____)_____
May we leave a message at this number? ❑ Yes ❑ No
Secondary Phone: (____)_____Work Phone: (_____)_____

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ Italian

Dentist: _____
(First and Last Name)
Phone: _____

If YES, name of referring provider: _____

Race: ❑ Native American ❑ African American ❑ Asian ❑ White ❑ Hispanic ❑ Pacific Islander ❑ Other ❑ Unreported/Refused

Ethnicity: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Unreported/Refused

Date of Birth: _____ ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number: _____

Email: _____

**Responsible Party, if different from patient information above:**
(statements will be addressed to the responsible party)

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date of Birth: _____ ❑ Male ❑ Female

Phone: (_____)_____ Email: _____

Relationship to patient: _____

**Adult Emergency Contact:**

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____)_____ Alt. Phone: (_____)_____

Relationship to patient: _____

**INSURANCE INFORMATION:** If the patient is not the primary policy holder, the Responsible Party section above must be completed.

❑ Self Pay *(no insurance)* ❑ Patient IS the policy holder ❑ Patient IS NOT the policy holder

**Primary** Insurance Co.: _____ Policy Number _____

**Secondary** Insurance Co.: _____ Policy Number _____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

**SUBSCRIBER INFORMATION** (REQUIRED if patient is not the primary insurance policy holder):

Name: _____

Social Security #:_____ Date of Birth:_____

**PHARMACY INFORMATION:**

Name: _____

Location (City and Intersection):_____

_____

Phone: (_____)_____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Patient or Responsible Party **Signature** _____ Date _____

# Oral Surgery Health Questionnaire
## Gilbert T. Selkin, DMD., MD
## *Oral and Maxillofacial Surgery*

**Patient Name:** _____ **Birth Date:** _____ **Chart Number:** _____

Age: _____ Sex: _____ Height: _____ Weight: _____

**PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED. ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.**

1.) Are you in good health? ---------- Yes No
2.) Your last physical examination was on _____
3.) Are you under the care of a physician?---------- Yes No
If so, what is the condition that is being treated?
_____
4.) Name and telephone number of the physician
_____
5.) Have you had any serious illness, operation, or been hospitalized? ---------- Yes No

If yes, what was the problem and when?
_____
6.) Do you drink alcoholic beverages? ---------- Yes No
If yes, how many per week? _____
7.) Do you smoke or use tobacco products? ---------- Yes No
If yes, how many cigarettes per day? _____
8.) Do you take vitamins and/or supplements? -------- Yes No
9.) Do you use any recreational drugs?---------- Yes No
If yes, what kind? _____
How many times per month? _____
10.) Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ---------- Yes No
11.) Do you bruise easily? ---------- Yes No
12.) Have you ever required a blood transfusion? ------- Yes No
If yes, explain circumstances _____
_____
13.) Do you have any bleeding disorder such as anemia? Yes No
14.) Are you taking any drug or medicine? ---------- Yes No
If yes, what medication? _____
_____
15.) Are you taking any of the following?
A.) Antibiotics or sulfa drugs ---------- Yes No
B.) Anticoagulants (blood thinner) ---------- Yes No
C.) Medicine for high blood pressure ---------- Yes No
D.) Medicine for anxiety or depression ---------- Yes No
E.) Cortizone (steroids) ---------- Yes No
F.) Tranquilizers ---------- Yes No
G.) Aspirin ---------- Yes No
H.) Insulin, Tolbutamid ---------- Yes No
I.) Digitalis or drugs for heart problems ---------- Yes No
J.) Nitroglycerin ---------- Yes No
16.) Are you taking or have you ever taken:
A.) Bisphosphonates (Fosamax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos, or Zometa) for osteoprosis, or chemotherapy for multiple myeloma, etc? ---------- Yes No
B.)Fen-Phen (now or in the past) or related drug such as lonimin, Adipex, Phentramine, Fastin, Pondimin (fenfluramine), and Redux (dexfenfluramine) ---------- Yes No

17.) Do you grind your teeth at night? ---------- Yes No
18.) Do you have a history of jaw pain when opening and closing? ---------- Yes No
19.) Does your jaw pop or click when opening? --------- Yes No
20.) Has your jaw ever been stuck open or closed? ----- Yes No
21.) Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips? ---------- Yes No
22.) Are you pregnant? ---------- Yes No
23.) Are you allergic or have you reacted adversely to:
A.) Iodine ---------- Yes No
B.) Local Anesthetic ---------- Yes No
C.) Penicillin or other antibiotics ---------- Yes No
D.) Sulfa drugs ---------- Yes No
E.) Barbiturates, sedatives, sleeping pills ---------- Yes No
F.) Aspirin ---------- Yes No
G.) Soybean or egg ---------- Yes No
H.) Latex ---------- Yes No
I.) Other _____
24.) Have you had any adverse reaction associated with previous dental treatment? ---------- Yes No
If yes, please explain _____
_____
25.) Have you had any adverse reaction associated with previous medical treatment or surgery? ----- Yes No
26.) Have you had any adverse reaction or family history of adverse reaction to anesthesia? --------- Yes No.
27.) Have you ever received any radiation treatment to the jaws or any area of the head and neck for any reason? ---------- Yes No
If yes, What location?_____
When was treatment? _____
Doctor who performed treatment? _____
28.) Have you had any of the following illnesses? ------ Yes No
AIDS ---------- Yes No
Allergies ---------- Yes No
Anemia ---------- Yes No
Angina ---------- Yes No
Anxiety ---------- Yes No
Anaphylaxis ---------- Yes No

Arthritis ---------- Yes No
Artificial Joint Replacement ---------- Yes No
Asthma ---------- Yes No
Bipolar Disorder ---------- Yes No
Cancer ---------- Yes No
Diabetes ---------- Yes No
Depression ---------- Yes No
Emphysema ---------- Yes No
Epilepsy ---------- Yes No
Fainting ---------- Yes No
Glaucoma ---------- Yes No
Heart Attack ---------- Yes No
Hepatitis ---------- Yes No

High Blood Pressure ---------- Yes No
HIV Positive ---------- Yes No
Kidney Disease ---------- Yes No
Liver Problem ---------- Yes No
Low Blood Pressure ---------- Yes No
Lung Disease ---------- Yes No
Mental Illness ---------- Yes No
Rheumatic Fever ---------- Yes No
Stroke ---------- Yes No
Thyroid ---------- Yes No
Tuberculosis ---------- Yes No
Venereal Disease ---------- Yes No
Other: _____

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.
I have reviewed the health history form above

Patient Signature: _____Date: _____

Doctor Signature: _____ Date: _____

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**Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.**

**Release of Medical Information**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions electronically to your pharmacy.

Signature: _____Date:_____/_____/_____

**Financial Policy**

Payment is required for all services at the time they are rendered unless the patient is in an insurance plan with which we participate. For those patients, applicable co-payments and deductibles will be collected for services rendered. Once our office has received payment from your insurance, if for some reason insurance decides to pay your charges at a higher benefit level than what was quoted to our office at the time of service; we will then issue the patient a refund for the over payment amount or apply a credit on the account. **In an effort to ensure the most accurate refund amount please be advised that our office cannot issue any refunds until all line items have been finalized by your insurance.**

We accept payment in the form of cash, check, Visa and MasterCard. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Nicole Reed Medical Facial & Skin Surgery Center when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Nicole Reed Medical Facial & Skin Surgery Center for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments.

In addition to the above, if I am a Medicare patient, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____Date:_____/_____/_____

**Privacy Practices (HIPAA)**

By signing below, I authorize The Facial & Skin Surgery Center, and whoever may be employed or assistant in administration to administer care as is deemed necessary.

Signature: _____Date:_____/_____/_____

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# Some facts about Dental & Medical Insurance

Over 50 % of patients seeking dental care have some type of Dental Insurance-
Or dental "Assistance", as it should be called. Like Medical Insurance, **dental insurance is designed to pay only a portion of the cost of dental treatment.**

**Your employer** has made this coverage available to you, and the type of benefit you receive depends upon the type of contract that was chosen with the insurance company. Your employer buys a special contract at a special fee (or premium) and includes as many or as few benefits as the employer is willing to pay for.
**Keep in mind that your oral surgeons fees or services are in no way reflective of what your insurance deems to be "Usual and Customary" by your insurance company, because remember….your employer selected your plan for you, not your oral surgeon.**

Benefits vary from policy and the premiums that are paid are usually reflective of your individual plan.
(I.e. Higher premium= Higher usual and customary rates and fewer exclusions and limitations)

**Unfortunately it would be impossible for Dr. Gilbert. T. Selkin to determine each and every patient's policy provisions and limitations. While we are happy to assist you in filing your claims, please keep in mind that is offered as a courtesy. We will file your insurance for you but if they do not pay within 60 days, it is your responsibility to pay our office and follow up with your dental and medical insurance.**

Occasionally there are services that are selected that are "Non- covered" services which vary from plan to plan and policy to policy.

Some services may include but are not limited to the following:

X- Rays
- Panorex
- Periapical

Dental implants & wisdom teeth extractions
Extractions
Sedation
Biopsy & excision of oral lesions

**Your oral health should NEVER be dictated by what your dental or medical insurance will or will not cover. Please allow us the opportunity to answer any questions that you may have regarding your insurance coverage.**

Patient or Responsible Party **Signature**_____Date_____

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# Surgery Cancellation Policy Effective 12/01/2010

**Patients, or legal guardians of patients under the age of eighteen, MUST sign and date below before medical care can be rendered.**

At the Facial & Skin Surgery Center we strive to provide the best and most complete patient care. In an attempt to preserve patient care, we have a Surgery Cancellation Policy that allows us to schedule appointments for all patients. When a surgery is scheduled, that extended period of time has been set aside for you. When it is missed, that time cannot be used for surgery for another patient, or filled with appointments for patients that urgently need the care.

We request that you please give our office 24 hour notice in the event that you need to reschedule or cancel your surgery with the physician or physician assistant. This allows other patients in need of care to be scheduled in that appointment time. It also makes it possible to reschedule your appointment more efficiently. Patients failing to provide 24 hours notice that they can not make their surgery as scheduled will have a charge of $100 added to their account. Please note that this charge is the financial responsibility of you, the patient, and will not be paid by your insurance company. We thank you for your cooperation in this manner so that each patient can receive the treatment and medical attention that they need and deserve.

**I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

I, _____ (print name), have read, understand, and will comply with the Facial & Skin Surgery's Center Surgery Cancellation Policy.

_____ _____
Printed Name of the Patient Relationship to Patient (if patient is a minor)

_____ _____
Signature of Patient or Responsible Party if a Minor Date

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## Authorization to Leave a Voicemail

Please provide number(s) **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures on your voicemail.
Primary (_____) _____ Secondary (_____) _____

## Authorization to Send an Email Message

Please provide an email address below **ONLY IF** you approve us to send **DETAILED** information regarding your appointment, billing, test results, diagnosis, and procedures in an email.
**Email address: _____**

We also offer you to have access to your account online through our web portal, giving you the option to look at billing information, appointment times, and to send the providers questions or messages through the internet. Would you like to be web enabled through our web portal? ❑ Yes ❑ No

## Personal Representative Authorization for Medical Release Form

Under HIPAA requirements, we are not allowed to discuss any of your health information with anyone else without your consent.
I authorize this facility to speak to the following family members or my personal representative regarding

❑ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
❑ Only the following types of information: _____

The above medical information shall only be released to the following person(s):

1._____Relationship: _____ Phone number: _____
2._____Relationship: _____ Phone number: _____
3._____ Relationship: _____ Phone number: _____

## Authorization to Send a Text Message

Please provide a number **ONLY IF** you approve us to leave **DETAILED** information related to appointments, billing, test results, diagnosis, and procedures in a text message. (_____)_____

By signing below I understand and agree to all stated and filled in above; I also understand my rights are protected by the Privacy Act (HIPAA) and that I may request a copy of this Act at any time.

Name **(PRINTED)** _____

Signature_____

Date_____

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## *CONSENT FOR TREATMENT OF MINOR CHILD*

I hereby authorize The Facial & Skin Surgery Center, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to:

CHILD'S NAME: _____

ADDRESS: _____

CITY, STATE: _____ ZIP: _____

## *MEDICAL RELEASE SPECIAL AUTHORIZATION*

I, _____, authorize the following name person/persons to authorize (medical) treatment for my child by The Facial & Skin Surgery Center. I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing.

| NAME OF PERSONAL REPRESENTATIVE | RELATIONSHIP |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Signed by: _____
Relationship to Child: _____
Date: _____