J. MARK LAWHON, DMD
ORAL & MAXILLOFACIAL SURGERY, P.A.
FLORENCE DENTAL IMPLANT CENTER & FACIAL COSMETICS

New Patient Information Packet

Instructions:

1. Please fill out all the fields in “blue” (all fields are required) you my type in or print out and write in answers.
2. Click the “Print Form Button” at the bottom of the last page.
3. Bring this packet with you at your first visit; this will save you some time.

Please call our office should you have any questions about this form or how to fill it out.

843-669-7044

Reset All Form Fields

Medical and Health History Questionare

Last Name:	**First Name:**	**MI:**	**Date of Birth**	**Phone**:

Who referred you to this office_____

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Have you ever:	**YES**	**NO**
Had a serious illness?	☐	☐
Been hospitalized in the last 5 years	☐	☐
Had a surgery or an operation in the past	☐	☐
Received doctor's care in the past 6 months	☐	☐
Had excessive bleeding after a surgery	☐	☐
Had a blood transfusion? If so when?	☐	☐
Had a problem with local or general anesthesia	☐	☐
Been immunosuppressed or have problems of the immune system	☐	☐
Been treated for an alcohol or drug usage problem	☐	☐

Are You:

Presently wearing contact lenses	☐	☐
Allergic to latex or rubber products or tape materials	☐	☐
Allergic to any drug or medication	☐	☐
Please list drugs allergies:_____		
Any other allergies?_____		
Taking or have you taken prescription medications or drugs for weight loss	☐	☐
What medictions (including non-prescription) are you currently taking?	☐	☐
_____		
Do you currently smoke or chew tobacco products	☐	☐
Did you smoke or chew tobacco products in the past	☐	☐
Are you planning to be sedated (nitrous oxide, I.V. sedation) or go to sleep (general anesthesia)	☐	☐
Did you come with someone responsible who can take you home	☐	☐
When was the last time you had anything to eat or drink?		
_____		

Have you ever:	**YES**	**NO**
Seizure disorders/epilepsy/convulsions	☐	☐
Migraine headaches	☐	☐
Stroke or Transient ischemic attacks (TIA's)	☐	☐
Mental health problems or psychiatric disorders	☐	☐
Glaucoma	☐	☐
Facial trauma	☐	☐
Sinus or nasal problems	☐	☐
HIV / AIDS	☐	☐
Rheumatic fever or rheumatic heart disease	☐	☐
Heart valve replacements, Heart Murmur	☐	☐
Congential heart defect	☐	☐
Asthma	☐	☐
Emphysema or bronchitis	☐	☐
Hepatitis/jaundice or liver disease	☐	☐
Stomach ulcers, gastritis, acid reflux, or hyperacidity	☐	☐
Colitis, diverticulitis or Crohn's disease	☐	☐
Kidney disease	☐	☐
Thyroid disease	☐	☐
Diabetes	☐	☐
A blood disorder, bleeding disorder	☐	☐
Anemia or sickle cell anemia	☐	☐
Hip or knee replacement	☐	☐
Cancer (now or in the past)	☐	☐
Radiation therapy or x-ray treatments for cancer	☐	☐
Cortisone or steroid therapy	☐	☐
Hypertension / High Blood Pressure	☐	☐
Implants, transplants, or synthetic grafts placed anywhere in the body	☐	☐
Do you have any other dental/medical problems, or diseases that were not listed that we should know about	☐	☐
Do you take a blood thinner	☐	☐

Insurance Information

Patient Name:

*** All information must be completed or insurance cannot be filed***

Is the patient a full time college student? (Yes / No) If Yes, Where _____

☐ ☐

If yes, you must provide our office with proof of student status before we can file you claim.

Primary **Dental** Ins. Co.: _____ Telephone #: _____

Insurance Address: _____ Group #: _____

Subscribers name:_____ DOB: _____ SS #: _____

Subscribers Employer: _____ Insurance ID: _____

Primary **Medical** Ins. Co.: _____ Telephone #: _____

Insurance Address: _____ Group #: _____

Subscribers name:_____ DOB: _____ SS #: _____

Subscribers Employer: _____ Insurance ID: _____

**** We DO NOT process secondary insurance for payment for your surgery ****

Secondary **Dental** Ins. Co.: _____ Telephone #: _____

Insurance Address: _____ Group #: _____

Subscribers name:_____ DOB: _____ SS #: _____

Subscribers Employer: _____ Insurance ID: _____

Secondary **Medical** Ins. Co.: _____ Telephone #: _____

Insurance Address: _____ Group #: _____

Subscribers name:_____ DOB: _____ SS #: _____

Subscribers Employer: _____ Insurance ID: _____

I understand that the insurance will be submitted to the carrier based on the information I have provided. I understand that it is my responsibility to provide this office with a copy of the insurance cards in which I have coverage with. I must notify the office if there are any changes with my insurance. I understand that Secondary insurance is not filed for payment for services. Secondary can be processed by the insured for payment after the primary insurance has been processed and completed.

I understand that if I have not received an explanation of benefits from the insurance company within 30 days from the date of surgery that I should contact Dr. Lawhon's office as well as the insurance company. I understand that the insurance will send an EOB to the insured approximately 2 weeks before the provider should receive payment.

*** I understand that regardless of the insurance I am **FULLY RESPONSIBLE** for the charges for the services provided to the patient. ***

Signature of Person providing Insurance Information: _____

Date: _____ Relationship to Patient: _____

Financial Responsibility

Please complete entire form

Patient Name: DOB: SSN#:

Individual/ Guardian Responsible For This Account: _____

Relationship to Patient: _____

Address If Different From Patient Address: _____

SSN# _____ Home Phone: _____ Cell: _____

Employers Name: _____ Phone #: _____

Employers Address: _____

Current Position: _____ How Long Employed: _____

Previous Employer: _____ Phone #: _____

……

Spouses Name: _____ Spouse Employer: _____

Address Of Employer: _____ Phone: _____

Position: _____ How Long Employed: _____

Cell Number of Spouse: _____

***** PAYMENT FOR TODAYS SERVICES ARE DUE TODAY*****

PAYMENT OF FEES are the responsibility of the patient and the above stated individual.

NOT THE INSURANCE COMPANY.

Balances remaining after any insurance payments expected or denial are due 15 days following notification, regardless of when the services were rendered. It is your responsibility to notify and send our office copies of any documents you receive from your insurance regarding paying your claim : Request for x-rays, information needed, etc.

I (the responsible individual) certify that I have had the opportunity to read and understand the financial policy for the office and agree to abide by that policy for services rendered.

Signature: _____ Date: _____

J. MARK LAWHON, DMD

Oral & Maxillofacial Surgery

611 West Palmetto Rd - Florence, SC 29501
Phone (843) 669-7044 Fax (843) 669-7052

DIPLOMATE
American Board Of Oral And Maxillofacial Surgery

FELLOW

American Association Of Oral And Maxillofacial Surgeons

American College Of Oral And Maxillofacial Surgeons

American Dental Society Of Anesthesiology

www. drlawhon.com

Medical Release

Patient Name: _____

DOB: _____

I authorize you to send my Medical records from your office to: J. Mark Lawhon, DMD.

Signature:_____

J. MARK LAWHON, DMD

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #:_____Social Security #:_____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Dr. J Mark Lawhon**

Telephone: **843-669-7044** Fax: **843-669-7052**

E-mail:_____

Address: **611 West Palmetto Street, Florence, SC 29501**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIETN'S CHART.

Click here to print the form

Reset all fields (WARNING: this will remove all current answers)