



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 may 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

Medical and Health History Questionnaire

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

	YES	NO		YES	NO
Have you ever:			Have you ever:		
Had a serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders/epilepsy/convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized in the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Had a surgery or an operation in the past	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Transient ischemic attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>
Received doctor's care in the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	Mental health problems or psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Had excessive bleeding after a surgery	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Had a blood transfusion? If so when?	<input type="checkbox"/>	<input type="checkbox"/>	Facial trauma	<input type="checkbox"/>	<input type="checkbox"/>
Had a problem with local or general anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus or nasal problems	<input type="checkbox"/>	<input type="checkbox"/>
Been immunosuppressed or have problems of the immune system	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Been treated for an alcohol or drug usage problem	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever or rheumatic heart disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart valve replacements, Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Are You:			Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>
Presently wearing contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to latex or rubber products or tape materials	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to any drug or medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Please list drugs allergies: _____			Stomach ulcers, gastritis, acid reflux, or hyperacidity	<input type="checkbox"/>	<input type="checkbox"/>
Any other allergies? _____			Colitis, diverticulitis or Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Taking or have you taken prescription medications or drugs for weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
What medications (including non-prescription) are you currently taking?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
_____			A blood disorder, bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Anemia or sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
			Hip or knee replacement	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer (now or in the past)	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation therapy or x-ray treatments for cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Cortisone or steroid therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Hypertension / High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
			Implants, transplants, or synthetic grafts placed anywhere in the body	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently smoke or chew tobacco products	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other dental/medical problems, or diseases that were not listed that we should know about	<input type="checkbox"/>	<input type="checkbox"/>
Did you smoke or chew tobacco products in the past	<input type="checkbox"/>	<input type="checkbox"/>	Do you take a blood thinner	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning to be sedated (nitrous oxide, I.V. sedation) or go to sleep (general anesthesia)	<input type="checkbox"/>	<input type="checkbox"/>			
Did you come with someone responsible who can take you home	<input type="checkbox"/>	<input type="checkbox"/>			
When was the last time you had anything to eat or drink?					

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: _____

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****** 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: _____

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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 TODAY'S 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 ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.**