

INFORMATION

****ALL RESPONSES ARE KEPT CONFIDENTIAL****

PATIENT INFORMATION

DATE _____

NAME _____ D.O.B. _____ AGE _____ SEX: M F MARITAL STATUS: M S W D

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK _____ CELL PHONE _____

SOC. SEC# _____

EMPLOYER _____ ADDRESS _____

E-MAIL _____

.....
DENTAL INSURANCE COMPANY _____ ID# _____ GP# _____

MEDICAL INSURANCE COMPANY _____ ID# _____ GP# _____

NAME OF POLICYHOLDER _____ D.O.B. _____ SOC. SEC.# _____

RELATION TO PATIENT _____ POLICYHOLDER ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

POLICYHOLDER EMPLOYER _____ WORK PHONE # _____

SPOUSE GUARDIAN INFORMATION (please check one)

NAME _____ ADDRESS _____

D.O.B. _____ SOC. SEC# _____

EMPLOYER _____ HOME PHONE# _____ WORK PHONE # _____

.....
NAME OF EMERGENCY CONTACT (SOMEONE NOT LIVING WITH YOU) _____

PHONE _____ RELATIONSHIP _____

WHY ARE WE SEEING YOU TODAY? _____

WHO ARE WE TO THANK FOR SENDING YOU TO SEE US TODAY? _____

.....
If you do not have insurance, 100% of fees are due at the time of service. If your account is turned over to collections, you will be responsible for any and all collection and reasonable attorney fees.

I will be paying today by CASH: _____ CHECK: _____ CREDIT CARD: _____

By signing below, you acknowledge and understand that your coverage and/or fees are estimates only. This is not a guarantee of payment and you are solely responsible for your account of any and all charges.

I hereby certify that I have received and / or have been offered a copy of this office's Privacy Policies Notice.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____

MEDICAL HISTORY

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NAME _____

MEDICAL DOCTOR _____ CITY _____ STATE _____

REFERRING DENTIST _____ CITY _____ STATE _____

CHECK "YES" OR "NO" IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

YES NO	YES NO	YES NO
___ ___ DIABETES	___ ___ KIDNEY TROUBLE	___ ___ VENEREAL DISEASE
___ ___ RHEUMATIC FEVER	___ ___ JAUNDICE	___ ___ A.I.D.S.
___ ___ HEART MURMUR	___ ___ HEPATITIS	___ ___ HIGH/LOW BLOOD PRESSURE
___ ___ TUBERCULOSIS	___ ___ ANEMIA	___ ___ CANCER _____
___ ___ HEART TROUBLE	___ ___ BLEEDING PROBLEMS	___ ___ STROKE
___ ___ LIVER TROUBLE	___ ___ EPILEPSY	___ ___ PREGNANT (AT PRESENT) IF YES, WHEN DUE _____
___ ___ LUNG TROUBLE	___ ___ SEIZURES	___ ___ RADIATION TREATMENT

___ ___ STOMACH-COLON-BOWEL TROUBLE

___ ___ UNUSUAL REACTION TO ANY ANESTHETIC (IF YES, WHAT?) _____

HAVE YOU EVER BEEN IN THE HOSPITAL OR HAD OUTPATIENT SURGERY? _____ IF YES, WHAT FOR (GIVE DATES) _____

DO YOU SMOKE OR USE ANY FORM OF TOBACCO? YES _____ NO _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, WHAT _____

ARE YOU ALLERGIC TO LATEX? YES _____ NO _____

ARE YOU TAKING ANY MEDICATIONS, INCLUDING BIRTH CONTROL PILLS? IF YES, WHAT _____

DO YOU WEAR CONTACT LENSES? YES _____ NO _____ IF YES, ARE YOU WEARING THEM NOW? _____

OTHER MEDICAL INFORMATION: _____

Medical History Update:

Date _____ By _____
Date _____ By _____

Date _____ By _____
Date _____ By _____

The Oral and Facial Surgery Center of Kentucky
1105 Mary T. Meagher Drive
Elizabethtown, KY 42701
1 (270) 737-1733

Date _____

Patient: _____
Employer: _____
Claim Group: _____
SSN/ ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: The Oral and Facial Surgery Center of Kentucky
1105 Mary T. Meagher Drive
Elizabethtown, KY 42701

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: The Oral and Facial Surgery Center of Kentucky
1105 Mary T. Meagher Drive
Elizabethtown, KY 42701

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this _____ day of _____, 20 _____

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder