

# 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 have insurance, we collect 40% of the total cost at the time of service. If there is no insurance, 100% of the fees are due. 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. If your insurance plan has a 12 month waiting period and you decide to have your procedures done you are responsible for all charges. If a balance remains on your account for over ninety (90) days, we reserve the right to charge you interest in the past due balance in the amount of 1.5% per month. If your account is turned over to collections, you acknowledge and agree that you will be responsible for any and all court costs, filing fees, and a reasonable attorney's fee.**

**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 \_\_\_\_\_

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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