Kentucky Oral Surgery & Dental Implant Center

Oral & Maxillofacial Surgery

Thad R. Schulten, D.M.D.

Patient's First Name _____ M.I.____ Last Name _____

Street Address _____City & State _____Zip Code_____

Home Phone _____Cell Phone _____Work Phone _____ Ext. _____ Married: Yes / No

DOB_____ Age _____ Sex: M / F Height _____ Weight_____ SSN _____/_____/_____

Parent Name (if patient is a minor) _____ Parent Cell Phone _____

PERSON RESPONSIBLE FOR THE ACCOUNT (If other than patient)_____Relationship_____

Address:_____Phone:_____DOB_____ SSN_____/_____/_____

REFERRAL SOURCE: **please circle** Dentist Orthodontist Physician Sponsorship Program Online/Ins. Company Other

Your Dentist _____ Your Orthodontist _____

Primary Physician _____ Cardiologist_____

****PREFERRED PHARMACY _____ _____ZIP CODE_____PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Dental Insurance Company Name & Phone #	Employer Name	Identification #	Group #
Name of Insured	S.S. # of Insured	Relationship to patient	Date of Birth
Medical Insurance Company Name & Phone #	Employer Name	Identification #	Group #
Name of Insured	S.S. # of Insured	Relationship to patient	Date of Birth

SECONDARY INSURANCE:

Dental Insurance Company Name & Phone #	Employer Name	Identification #	Group #
Name of Insured	S.S. # of Insured	Relationship to patient	Date of Birth
Medical Insurance Company Name & Phone #	Employer Name	Identification #	Group #
Name of Insured	S.S. # of Insured	Relationship to patient	Date of Birth

I hereby authorize Kentucky Oral Surgery & Dental Implant Center to release any medical or other information necessary to process this claim.

I hereby authorize payment of medical or dental benefits directly to Kentucky Oral Surgery & Dental Implant Center.

_____ _____

Signature of Patient/Parent Date

I authorize the release of my medical record from this practice to conferring doctors for the purpose of treatment.

_____ _____

Signature of Patient/Parent Date

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

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6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Artificial joints or Body Parts? (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
   - T. HIV/Positive ARC..... Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ..... Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N
   - K. Please provide list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

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8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

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9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
14. Have you ever had a bone density scan? ..... Y N
15. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date | Signature of Person Completing Health History | Doctor's Initials

Acknowledgement of Receipt
Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices and understand how my protected health information may be used by Kentucky Oral Surgery as described in the notice.

_____
(Print) Patients Name

_____ _____
Signature of patient or parent Date

Telephone Reminders

When trying to reach our patients for appointment reminders and treatment information, we are permitted to leave a message at the following numbers:

Cell Phone: _____ Home Phone: _____

_____ Other: _____

Financial Contact Information Disclosure

You agree, in order for us to service your account or to collect monies you may owe, we may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read and understand the above information.

Signature _____ Date _____

Cell Phone Use

The use of cell phones in our office can violate a patient's right to privacy; therefore, cell phone use is prohibited while you're in our office. Additionally, the use of cell phones for audio or video recording purposes, as well as taking photos is strictly prohibited.

I understand the cell phone policy and agree not to use my cell phone while in the office of Kentucky Oral Surgery and Dental Implant Center.

_____ _____
Signature of patient or parent Date

Financial Policy

Payment is due in full at the time services are rendered unless an estimate was provided.

We accept most commercial dental insurance plans and will submit a claim for you. You will be provided with an **ESTIMATE** of your cost based off your primary dental benefits and the estimate will be due at the time services are rendered, regardless of other dental coverage. We will file up to two insurance plans for you but there is no guarantee both will pay.

- We cannot combine a dental discount plan with other insurance.
- We cannot guarantee insurance payment, even when a Pre-Determination has been provided.

We do not participate with any medical insurance plans; however, we can submit a claim for you to be reimbursed. Submission of a claim does NOT guarantee reimbursement.

We have **Opted Out of MEDICARE** - neither our office, nor the patient, can submit a claim for reimbursement to Medicare for **MEDICAL** services, however, we can still treat those patients on a self-pay basis. Some Medicare plans have associated dental plans which can have different levels of coverage for DENTAL services. We accept a few of these plans, but not all.

WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER CARD and CARE CREDIT.

A $25 fee is charged for any returned check.

If the insurance hasn't paid the claim after sixty (60) days, the patient will need to pay the account in full.
Any insurance payment will be credited to the account, and patient refunded accordingly.

Any account not settled in 90 days will be turned over to a collection agency. I understand that, in the event legal action is required to enforce payment on this account, I will pay any interest, court costs, expenses, attorney fees and other costs incurred and/or expended because of such proceedings.

I assign to Kentucky Oral Surgery and Dental Implant Center all benefits due me for treatment under an applicable policy of Insurance.

I understand that I am financially responsible for all charges and agree to pay Kentucky Oral Surgery and Dental Implant Center for all services. My signature verifies that I have read, understood and accept these policies.

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Signature of Patient/Responsible Party Date