Welcome To Dr. Kelly's Office

PATIENT INFORMATION

DATE _____

○ Mr. ○ Mrs. ○ Ms. ○ Dr. **First Name** _____ **M.I.**___ **Last Name** _____ **Preferred**_____

Gender: ○ Male ○ Female **Birthdate** _____ **Age** _____ **Social Security Number** _____

Mailing Address_____Apt._____City_____State_____Zip_____

Home Tel (_____)_____ **Cell** (_____)_____ **Emergency** (_____) _____

Email Address _____ Have you ever been a patient of our practice? ○ Yes ○ No

Referred By _____ _____ Has a family member ever been a patient of our practice? ○ Yes ○ No
First Name Last Name

Dentist _____ **Orthodontist** _____ **Medical Doctor** _____

Employer _____ **Bus. Tel** (_____)_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

○ Self ○ Spouse ○ Mother ○ Father ○ Other

_____ _____ _____ _____
Relationship Name SS# Birthdate

_____ _____ _____ _____ _____
Billing Address City State Zip Phone

PRIMARY DENTAL INSURANCE

Insurance Name _____

Address _____

City_____ State _____ Zip_____

Employer _____

ID #_____ Group #_____

Subscriber _____ _____
First Name Last Name

Relation _____ ○ M ○ F

Birthdate _____ SS# _____

PRIMARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID #_____ Group #_____

Subscriber _____ _____
First Name Last Name

Relation _____ ○ M ○ F

Birthdate _____ SS# _____

SECONDARY DENTAL INSURANCE

Insurance Name _____

Address _____

City_____ State _____ Zip_____

Employer _____

ID #_____ Group #_____

Subscriber _____ _____
First Name Last Name

Relation _____ ○ M ○ F

Birthdate _____ SS# _____

SECONDARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID #_____ Group #_____

Subscriber _____ _____
First Name Last Name

Relation _____ ○ M ○ F

Birthdate _____ SS# _____

ACCIDENT RELATED?

Is this visit related to an accident? ○ Yes ○ No; Date of Accident _____

If Yes, what type? ○ Automobile ○ Work Related ○ Other_____

Insurance company handling the claim _____ Claim # _____

Name of Attorney/Adjustor _____ Telephone Number (_____) _____

Patient Name _____ **Birthdate** _____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records and will be considered confidential.

REASON FOR TODAY'S VISIT? _____

1. Height _____ Weight _____ Are you in good health? ○ Yes ○ No
2. Are you under the care of a physician? ○ Yes ○ No; **If so, for what are you being treated**? _____
3. Has a physician or dentist recommended that you take antibiotics prior to your dental appointments? ○ Yes ○ No
4. Have you ever had a serious head or neck injury? ○ Yes ○ No
5. Have you ever been hospitalized or had a major operation? ○ Yes ○ No**; If yes, explain** _____
   _____
6. Are you allergic to any of the following? ○ Aspirin ○Penicillin ○ Codeine ○ Local Anesthetics ○ Latex ○ Sulfa drugs ○ Other _____
7. Do you smoke, or have you ever smoked? ○Never ○ Former Use – How long: _____ Date quit: _____
   ○ Current Use -- How much: _____ How long: _____
8. Do you or have you ever chewed tobacco? ○ Never ○ Former Use ○Current Use
9. Marijuana Use: ○ Yes ○ No; If yes, how often? _____

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

- ○ AIDS/HIV Positive
- ○ Alzheimer's Disease
- ○ Anaphylaxis
- ○ Anemia
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Breathing Problems
- ○ Cancer
- ○ Chemotherapy
- ○ Chest Pains
- ○ COPD
- ○ Cold Sores/Fever Blisters
- ○ Convulsions
- ○ Cortisone Medicine
- ○ Dementia
- ○ Diabetes
- ○ Drug Addiction
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Fainting Spells/Dizziness
- ○ Frequent Cough
- ○ Frequent Headaches
- ○ Glaucoma
- ○ Heart Attack/Failure
- ○ Heart Murmur
- ○ Heart Pacemaker
- ○ Heart Trouble/Disease
- ○ Hemophilia
- ○ Hepatitis A
- ○ Hepatitis B or C
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hypoglycemia
- ○ Irregular Heartbeat
- ○ Kidney Problems
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Mitral Valve Prolapse
- ○ Osteoporosis
- ○ Pain in Jaw Joints
- ○ Psychiatric Care
- ○ Radiation Treatments
- ○ Renal Dialysis
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Shingles
- ○ Sickle Cell Disease
- ○ Sinus Trouble
- ○ Sleep Apnea
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Swelling of limbs
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Jaundice
- ○ Other _____
- ○ Other _____

ARE YOU NOW TAKING:		PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:
○ Yes ○ No	Blood Thinners (Coumadin, Plavix, Aspirin, Aggrenox, Xarelto, Eliquis, etc.?)	**Medication Name(s)**
○ Yes ○ No	Are you taking, or have you ever taken bone density meds (bisphosphonates) such as Fosamax, Boniva, Actonel, Zometa, Aredia, etc.)	

FOR WOMEN ONLY:

Is there a possibility of pregnancy? ○ Yes ○ No; If yes, expected delivery date: _____

Are you Nursing? ○ Yes ○ No

Are you on birth control? ○ Yes ○ No

Please note: Antibiotics may alter the effectiveness of birth control pills

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **(Parent or Guardian if minor)** To be signed in office **Date:** _____

Patient Name_____ **Birthdate** _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request.

Patients without insurance are requested to pay in full at the time the service is provided, unless other arrangements have been made.

If you have any dental and/or medical insurance, we will be happy to submit the claim on your behalf. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. You are ultimately responsible for all charges incurred. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

For your information, our office is contracted with Delta Dental Premier. For all other insurance carriers, Dr. Kelly is an out-of-network provider. Your insurance may not pay for services provided to you by our facility, or may reimburse at a reduced rate.

In addition to cash and checks, we accept all major credit cards. Returned checks will be subject to additional fees. We are pleased to offer financing for your surgery through Care Credit or Health Credit Services. If you are interested in either of these options, please ask our staff for more information prior to scheduling your surgery.

This signature is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) To be signed in office _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have also been given the opportunity to ask any questions I may have regarding this notice.

I also understand that any correspondence I receive from this office by mail or any information I request to be sent by email or facsimile, may be viewed by a 3rd party. By signing below I understand and accept the risk of these types of correspondence.

I allow this office to give my information to or answer any questions from (please check and provide the name for all that apply):

(☐ Spouse _____

☐ Parent _____

☐ Child _____

☐ Other _____
(Please Specify)

☐ None _____

Signature of patient: (Parent or Guardian if minor) To be signed in office _____ **Date:** _____

FOR OFFICE USE ONLY