

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 NoReferred 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 _____
(If self, skip to next section)

First Name	M	Last Name	SS#	Birthdate	
_____	_____	_____	_____	_____	
Billing Address		City	State	Zip	Phone

PRIMARY DENTAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID # _____ Group # _____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

PRIMARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID # _____ Group # _____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

SECONDARY DENTAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID # _____ Group # _____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber Birthdate _____ SS# _____

SECONDARY MEDICAL INSURANCE

Insurance Name _____

Address _____

City _____ State _____ Zip _____

Employer _____

ID # _____ Group # _____

Subscriber _____ Relation _____

Subscriber Address _____

City _____ State _____ Zip _____

Subscriber 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 _____

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.

Height:	Weight:	Do you consider yourself to be in good health?	Yes	No
Are you under the care of a physician?			<input type="checkbox"/>	<input type="checkbox"/>
If yes, what are you being treated for?				
Do you take an antibiotic prior to dental appointments due to a replacement heart valve or joint replacement?			<input type="checkbox"/>	<input type="checkbox"/>
If so, please specify:				
Are you ALLERGIC to any medications, or have a latex allergy?			<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list:				

SOCIAL HISTORY

Do you smoke, or have you ever smoked?	<input type="checkbox"/> Never	<input type="checkbox"/> Former Use - How long?	Date quit:
	<input type="checkbox"/> Current Use – How Much:		How Long:
Do you or have you ever chewed tobacco?	<input type="checkbox"/> Never	<input type="checkbox"/> Former Use - How long?	Date quit:
	<input type="checkbox"/> Current Use		
Marijuana use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Pain in Jaw Joints
<input type="checkbox"/> Anesthesia Problems (self / family history)	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Shingles
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> COPD	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> None of the above

Are you NOW taking, or have you EVER taken:

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

Blood Thinners? <input type="checkbox"/> None <input type="checkbox"/> Coumadin <input type="checkbox"/> Plavix <input type="checkbox"/> Aspirin <input type="checkbox"/> Aggrenox <input type="checkbox"/> Xarelto <input type="checkbox"/> Eliquis <input type="checkbox"/> Other	Medication Name(s)
Bone Density medications (bisphosphonates)? <input type="checkbox"/> None <input type="checkbox"/> Fosamax <input type="checkbox"/> Boniva <input type="checkbox"/> Actonel <input type="checkbox"/> Zometa <input type="checkbox"/> Aredia <input type="checkbox"/> Other	

FOR WOMEN ONLY:

Is there a possibility of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , expected delivery date: _____
Are you Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you on birth control? <input type="checkbox"/> Yes <input type="checkbox"/> 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) _____ **Date:** _____

Patient Name _____

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) _____ 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) _____ Date: _____

FOR OFFICE USE ONLY
