ELIZABETHTOWN
ORAL AND MAXILLOFACIAL SURGERY
914 N. Dixie Ave. Ste. 207 • Elizabethtown, KY 42701
(270) 737-6969

OFFICE FINANCIAL POLICY

It is the policy of this office to make complete payment arrangements at the time of the office visit. This may be handled in one of the following ways:

1. If you are here for a consultation, payment for the office visit and any x-rays is expected today. The fee for any indicated surgery will be discussed with you.

2. If you have dental insurance, or medical insurance that covers Oral Surgery, your portion of charges (the co-payment) is expected at the time services are performed. We will call your insurance company to verify your coverage and collect information regarding your anticipated coverage benefits. We will refund any overpayment to you or send you a bill for any underpayment.

3. If you do not have dental insurance, payment in full is expected at the time of surgery, unless prior arrangements are made with the office manager. In addition to cash and checks, we also accept Visa and Mastercard, or other monthly payment options.

4. We welcome and encourage frank discussion of services and fees prior to treatments in order to avoid misunderstandings.

This is to certify that I, ______________________________, accept full responsibility for all charges incurred by (patient) ______________________________ for diagnostic/surgical treatments performed by Dr. Jones and/or associates, as s necessary in their judgment.

All amounts not paid within ninety (90) days after the day of treatment will be considered in default and subject to certain delinquency charges, which I agree to pay. It is understood by me that the delinquency charges will be computed by applying a rate of one (1) percent per month, which is an annual rate of twelve (12) percent, to the unpaid balance beginning ninety (90) days after treatment, until paid. It is understood by me that should my account be turned over for collection, then I will be responsible for collection costs, including reasonable attorney's fees.

*** I authorize release of all medical/dental records necessary to process an insurance claim and hereby assign benefits to Dr. Jones, DMD, MD.

____
Signature

____
Date

____
Social Security Number

HEALTH HISTORY

NAME:______________________________

ADDRESS:______________________________ DATE:__________

	YES	NO	REMARKS
1. What is your present health status?			
2. Have you recently been under medical treatment?	☐	☐	

3. Do. you have or have you had any of the following:

	Yes	No		Yes	No
A Heart Ailment (murmur, angina, heart attack, heart failure, rhythm problems	☐	☐	Seizure Disorder	☐	☐
			Arthritis	☐	☐
			Thyroid Disease	☐	☐
Rheumatic Fever	☐	☐	Blood Disease	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Lung Disease / TB	☐	☐	Glaucoma	☐	☐
Asthma or Bronchitis	☐	☐	Stomach or Intestinal Disease	☐	☐
Liver Disease / Hepatitis	☐	☐			
Tumors, Growths or Cancer	☐	☐	Kidney Disease	☐	☐
Nervous or Psychiatric Disorders	☐	☐	Illicit Drug Abuse	☐	☐
Sinus, Nasal or Ear Disease	☐	☐	HIV infection or AIDS	☐	☐
Osteoporosis	☐	☐	Other __________	☐	☐

	YES	NO	
4. Have you had any major operations? Please list previous operations:______________________________	☐	☐	
5. Have you had any bleeding or healing problems?	☐	☐	
6. Are you presently taking any medications? **INCLUDING DIET PILLS**	☐	☐	
Please List: ______________________________	☐	☐	
7. Are you allergic to any FOODS or DRUGS? (Including Eggs) Please list: ______________________________	☐	☐	
8. Have you had any difficulties with General anesthesia?	☐	☐	
Local anesthesia?	☐	☐	
9. Have you had radiation treatments?	☐	☐	If Yes, Please Explain:__________
10. Do you smoke? Amount:	☐	☐	
11. Do you wear contact lenses?	☐	☐	
12. Are you pregnant?	☐	☐	
13. Do you have any history of medicines for osteoporosis (IV injections or oral medications taken weekly or monthly)?	☐	☐	

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PATIENT'S FULL NAME:_______________ DATE OF BIRTH:_______________

PATIENT'S ADDRESS: _______________ CITY _______ ST____ ZIP _______

PATIENT'S HOME PHONE: _________ CELL PHONE: _________ WORK PHONE: _________

PATIENT'S SOCIAL SECURITY NUMBER: _______________ PATIENT'S AGE:_______

PATIENT'S MARTIAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED

PERSON RESPONSIBLE FOR THIS ACCOUNT (IF OTHER THAN PATIENT) _______________

PERSON RESPONSIBLE SOCIAL SECURITY NUMBER: _______________

PATIENT/PARENT EMPLOYER: _______________

SPOUSE'S NAME: _________ EMPLOYER: _________ WORK PHONE: _________

DO YOU HAVE DENTAL INSURANCE? YES OR NO DO YOU HAVE MEDICAL INSURANCE? YES OR NO

IF YES, COMPLETE THE INSURANCE INFORMATION LISTED BELOW: Dental only Below

CARDHOLDER'S NAME (IF OTHER THAN PATIENT) _______________

SOCIAL SECURITY NO._______________ DATE OF BIRTH: _______________

CARDHOLDER'S EMPLOYER _______________ ADDRESS:_______________

CITY:_________ ST: _________ ZIP: _________

INSURANCE COMPANY NAME: _______________ GROUP#: _______________

ADDRESS: _________ CITY: _________ ST: _____ ZIP: _________

Pharmacy:Name &Phone:_______________

REFERRED BY: _______________

NAME OF DENTIST: _______________

NAME OF PHYSICIAN: _______________

EMERGENCY CONTACT:_______________

HOME PHONE (OTHER THAN PATIENT'S):_______________ WORK#: _______________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS OKAY TO SPEAK WITH _______________ REGARDING MY TREATMENT AND ACCOUNT

I _______________ , HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE _______________ DATE _______________