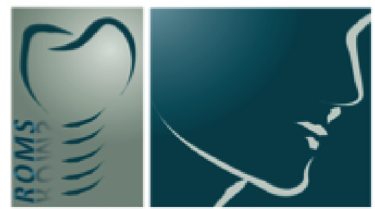
Richmond Oral and Maxillofacial Surgery, LLC
1004 Oak Drive
Richmond, IN 47374
(765) 935-1997



PATIENT INFORMATION (Please Print)

Patient Name: ______________________________ **Sex:** M F **Marital Status:** Ch S M D W **Birth Date:** _____________ **SS#:** ______________ **Age:** _____

Patient Address: ____ **City:** ________________________ **State:** ________ **Zip:** ____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)______________________

Employer: ____ **Position:** ____

Employer Address: ____ **City:** ________________________ **State:** ________ **Zip:** ____________________

Referred By: _____________________________ **What is the purpose of seeing the doctor today?** ____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Patient ☐ Father ☐ Mother ☐ Husband ☐ Wife **Name:** _______________________________ **Birth Date:** ___________ **SS#:** _______________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)______________________

Employer: ______________________________ **Position:** ________________________ **Employer Address:** ____

Spouse's or Parent's Name (other than responsible party): ____ **Birth Date:** _____________ **SS#:** _______________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Home Phone: (_______)______________________ **Cell Phone:** (_______)______________________ **Work Phone:** (_______)______________________

Employer: ______________________________ **Position:** ________________________ **Employer Address:** ____

Name of Relative (other than living with you): ___________________________________ **Relationship:** _________________ **Phone:** (______)__________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Name of Friend: ____ **Phone:** (______)__________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

INSURANCE COMPANY INFORMATION (Primary)

Name of Company: ____ **Phone:** (_______)______________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both **Group #:** ____________________________ **Employer:** ____

Name of Insured (person who carries insurance): ____ **Relation of Patient to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex of Insured: M F **Insured's Birth Date:** __________________ **Phone:** (______)_________________ **SS#:** _________________ ***or* ID#:** ___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

INSURANCE COMPANY INFORMATION (Secondary)

Name of Company: ____ **Phone:** (_______)______________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both **Group #:** ____________________________ **Employer:** ____

Name of Insured (person who carries insurance): ____ **Relation of Patient to Insured:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex of Insured: M F **Insured's Birth Date:** __________________ **Phone:** (______)_________________ **SS#:** _________________ ***or* ID#:** ___________________

Address: ____ **City:** ___________________________ **State:** __________ **Zip:** _____________________

Today's Date: _______________________

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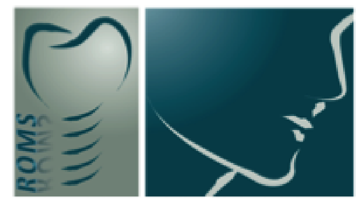

HEALTH HISTORY: For your safety please answer all questions carefully and honestly

Patient Name: ______________________________ **Phone:** (_____)__________ **Dentist Name:** ____________________________ **Phone:** (_____)___________

Height: _______ **Weight:** _______ **Are you in good health?** ☐ YES ☐ NO **Are you under the care of a physician?** ☐ YES ☐ NO **Date of last visit:** _______________ **Have there been any changes in your general health in the past year?** ☐ YES ☐ NO **If so, for what are you being treated?** ____________________________________ **Have you ever been hospitalized?** ☐ YES ☐ NO **List previous surgeries/dates:** ____

HAVE YOU EVER HAD:

	Y	N
1. Rheumatic fever?	☐	☐
2. Damaged heart valves/mitral prolapse?	☐	☐
3. Heart murmur?	☐	☐
4. Chest pain, angina?	☐	☐
5. Heart attack(s)?	☐	☐
6. Shortness of breath?	☐	☐
7. Irregular heart beat?	☐	☐
8. Cardiac pacemaker?	☐	☐
9. Heart surgery?	☐	☐
10. High blood pressure?	☐	☐
11. Low blood pressure?	☐	☐
12. Do you have anorexia or bulimia?	☐	☐
13. Kidney trouble?	☐	☐
14. Diabetes?	☐	☐
15. Are you on dialysis?	☐	☐
16. Hepatitis or liver disease?	☐	☐
17. A tumor or growth?	☐	☐
18. Radiation treatment/chemotherapy?	☐	☐
19. Thyroid trouble?	☐	☐
20. Blood transfusion?	☐	☐
21. Tuberculosis?	☐	☐
22. Asthma?	☐	☐
23. Hay fever/sinus problems?	☐	☐
24. Contact lenses?	☐	☐
25. Other medical concerns?	☐	☐

Explain: ____________________________________
____
____

DO YOU CURRENTLY HAVE:

	Y	N
1. Removable dental appliance?	☐	☐
2. Blood disorder?	☐	☐
3. Bleeding tendency (abnormal bleeding)?	☐	☐
4. Bruise easily?	☐	☐
5. Do you smoke?	☐	☐
6. Emphysema?	☐	☐
7. Any other lung trouble?	☐	☐
8. AIDS or HIV infections?	☐	☐
9. Sexually transmitted diseases?	☐	☐
10. Stroke?	☐	☐
11. Convulsions, epilepsy?	☐	☐
12. Mental health problems?	☐	☐
13. Habit-forming drugs?	☐	☐
14. Stomach ulcers?	☐	☐
15. Infectious mononucleosis?	☐	☐
16. Contagious diseases?	☐	☐

Explain: ____________________________________
____
____

MEDICATIONS:

What kinds are you taking/what for?

1. Anticoagulants? ___________________________
2. Other? ___________________________________
3. ____
4. ____
5. ____
6. ____

ALLERGIES:

Have you ever had a reaction to:	Y	N
1. Local Anesthetic? ________________	☐	☐
2. Penicillin? ________________	☐	☐
3. Other antibiotics? ________________	☐	☐
4. Other medication allergies: ________________ ________________	☐	☐
5. Egg allergy? ________________	☐	☐
6. Soy allergy? ________________	☐	☐
7. Latex allergy? ________________	☐	☐

WOMEN:

	Y	N
1. Could you be pregnant?	☐	☐
2. Estimated delivery date? _____________		
3. Are you nursing?	☐	☐
4. Are you taking birth control pills?	☐	☐
5. Have you ever been treated for osteoporosis? If so, list medications (Boniva, Actonel, Fosamax): ____________________	☐	☐

WOMEN NOTE: Antibiotics (such as erythromycin, etc.) and some pain medications may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Notice of Privacy Practices Acknowledgment
I have read and agree: ______________________
I have read and do not agree: ________________
Date: ____________________________________

I certify that I have read and understand the 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 may have made in the completion of this form.

Signature of patient/parent: ____ Date: ____________________

THE FACTS ABOUT INSURANCE

Please understand we are desirous to extend care to you and to work with you and any insurance coverage you may have.

1. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
2. It is imperative that we have an x-ray on file for our medical malpractice insurance and for your insurance coverage. If outside x-rays are brought to our office, there will be a duplication fee charged.
3. Unfortunately, insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is a pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows.
4. For your convenience we will ESTIMATE the portion of your total fee that your insurance company will cover. This is JUST AN ESTIMATE. After insurance benefits, you are responsible for ANY UNPAID BALANCE. We will ask you to bring with you at the time of surgery the ESTIMATED uncovered portion of the total fee.
5. If you desire to know exactly what your insurance coverage will be, prior to surgery, then we can pre-determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.
6. A finance charge of 1.5% per month will be added to your bill if payment has not been received within 60 days. This will allow adequate time for you to see that your insurance benefits have been paid to your satisfaction.
7. Should collection become necessary, the responsible party agrees to pay an additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney fees and court costs. I also authorize my insurance company to make payment directly to the doctor for services rendered and agree to pay any uncovered balance. I hereby authorize release of information for insurance purposes.

Thank you for your understanding in this matter. **Signature:** ____ **Date:** ____________________

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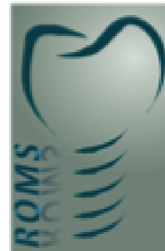

CONSENT FOR TREATMENT AND ANESTHESIA

The purpose and the nature of the dental and/or surgical treatment have been fully explained to me. I have been fully informed of and understand fully, all the risks to me that are involved in the performance of the treatment to be rendered. I understand that there is a possibility of complications developing during or after the treatment and these have been fully explained to me. I am now giving my free and voluntary informed consent for the treatment to be rendered. I have not been given or received a guarantee as to the results to be obtained from the treatment I am to receive. I have been told that there will be anesthesia administered and the type and nature of such administration and of the anesthesia itself, have been fully explained to me, and I do give my free and voluntary informed consent to same.

I have been informed and understand that some possible complications are pain, infection, swelling, bleeding, bruising, discoloration, temporary or permanent numbness and tingling of the lip, chin, tongue, gums, cheek or teeth, nausea, vomiting, allergic reaction, change in occlusion, temporomandibular joint difficulty (problems with opening and closing jaws), trismus (difficulty opening the mouth), injury to adjacent teeth and restorations, cracking and bruising of the lips and corners of the mouth, fractures of the jaw, delayed healing and pain, numbness or inflammation and unfavorable reactions to drugs and anesthetics. I understand that the removal of upper teeth may result in sinus complications, oral-antral fistulas and openings which may necessitate further surgery at a later date.

Such alternate treatment methods to the proposed surgical procedure as are available to treat my dental disorder were fully described to me prior to the performance of surgery. Today's surgical procedure has been explained to me in advance.

NOTE: You may have nothing to eat or drink for six to eight hours before general anesthetic. You must not drive a car or operate hazardous machinery for at least 24 hours after a general anesthetic. Someone responsible must take you home after a general anesthetic. You must not use alcohol or take any medications or drugs (other than those prescribed) without first consulting the treating doctor.

Patient Signature (parent/guardian if minor): ______________________________Printed Name___ ________________________________ Date: ____________

Doctor Signature _____________________________________ Witness: ____Date:___________

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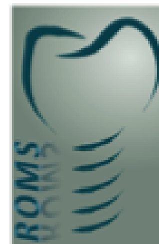

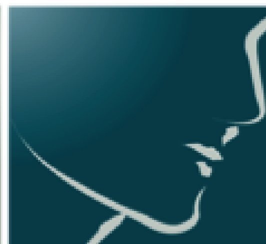

PRE-OPERATIVE INSTRUCTIONS

The following suggestions should be helpful in preparation for oral surgery at our office.

1. Plan a time with our receptionist that meets with your schedule and ours.
2. **For a morning surgery, do not eat or drink anything after midnight. With food or liquid in your stomach, it would necessitate canceling your surgery until another day.**
3. As an added prevention against infection please brush your teeth for 3-4 minutes, and swish with a mouthwash of your choice (be very careful not to swallow any mouthwash or water).
4. **Wear a short sleeved top or shirt which will make it easier for us to give your pre-operative medications.**
5. **Bring only one person with you (our waiting room can sometimes be crowded) to drive you home. You may be somewhat drowsy after your surgery, and will not be allowed to drive.**
6. You may need to have a post operative check-up approximately one week after your surgery.

We realize this is not a routine experience for you. Therefore, we will do all we can to minimize your apprehension. Please feel free to ask any questions you may have about what will be taking place.

Surgery Commitment ____

Day Date Time

We have committed this time to you. As a courtesy to us and others who might like to use this time, ***please give us 3 days notice if you are unable to keep this commitment.***