Kokomo Implant and Oral Surgery
2008 West Sycamore Street
Kokomo, IN 46901
(765) 452-0033

Kokomo
Implant and Oral Surgery

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

Physician 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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Office Financial Policy

1. If the patient does not have insurance, full payment is required at the time of surgery.

2. If you are having a single tooth removed, the entire fee (which we will provide you with prior to your services) will be due the day of the extraction. We will file your insurance claim for you and will reimburse you if any payment is made by your insurance company.

3. If the patient does have insurance, we do require a percentage of the total fee to be paid at the time services are rendered which is an **ESTIMATE** of your out of pocket expense. There may be an additional amount due after your insurance pays.

4. We are not responsible for benefits quoted to us by your insurance company whether this was received over the phone or if we have received a written predetermination on your behalf. Insurance companies will not guarantee coverage and/or payment to us until they receive an actual claim; therefore, regardless of the information that was given to us by your insurance company, either verbally or in writing, you may still be responsible for the entire fee for your treatment charged by this office.

5. The **ONLY** insurance companies that Kokomo Implant and Oral Surgery, LLC is contracted with are Delta Dental Premier dental insurance and Medicaid. Regardless of insurance coverage, the patient, or patient's legal guardian, is ultimately responsible for all fees charged by this office.

6. Sixty days will be allowed for your insurance company to process and pay your claim. If, after sixty days, no notice has been received from your insurance company, it is your responsibility to contact them directly and the entire balance is your responsibility at that time.

7. If your insurance requires a predetermination prior to the procedure, it is the patient's (or patient's legal guardian's/Power of Attorney's) responsibility to notify our office.

8. The parent (or legal guardian) that accompanies a minor to the office will be responsible for all fees charged. We cannot and will not contact someone who was not present in our office to ask for payment, such as in a divorce situation.

9. Should your account become past due, you will be responsible to pay all collection costs, including collection agency fees, attorney fees, and all court costs. These fees will be added to your balance and this new amount will be placed with our collection agency and become your responsibility to pay.

10. Please note that if any portion of your surgical care is rendered at a local hospital (in-patient or out-patient based care), there will be separate charges from the hospital that may or may not be fully covered by your insurance. Kokomo Implant and Oral Surgery, LLC is not financially affiliated with the hospital and is not responsible for and has no knowledge of these charges. It is your responsibility to check with your insurance to see what will or will not be covered.

11. This signature is on file as my authorization for the release of information necessary to process my claim and collect monies owed. I hereby authorize payment directly to Kokomo Implant and Oral Surgery, LLC of the insurance benefits otherwise due me. I certify that I am the legal guardian and/or power of attorney of the patient listed on this form. I have read the above financial policy and agree to all of the terms therein.

Patient_____ Patient's Signature _____Date _____

Parent or Legal Guardian Signature _____Date _____

Witnessed By _____Date _____

Kokomo Implant and Oral Surgery LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures that we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Kokomo Implant and Oral Surgery LLC
(765) 452-0033
2008 West Sycamore St
Kokomo, IN 46901

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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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, temporo-mandibular 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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