Kentuckiana Oral & Maxillofacial Surgery Associates, P.S.C.

Welcome

New Patient Profile

Thank you for selecting our practice for your Oral Surgery Maxillofacial needs.
Please complete this form completely in ink.
If you have any questions, please ask us – we are happy to assist!

Patient Information (Confidential)

Date _____

Name(Legal) _____ Birth date _____ Soc. Sec. # _____

Name (as it appears on Insurance card) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

If student, Name of School / College _____ Full or Part-time _____

Employer _____ Address _____

City _____ State _____ Zip Code _____

Emergency Contact Not Living With You ___ _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship To Patient _____

Soc. Sec. # _____ Birth date _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Referral Information

Whom may we thank for referring you ? _____

Insurance Information

Name of Insured _____ Birth Date _____ Relationship To Patient _____

Insured's Social Security # _____

Name of Employer _____

Name & Address of Dental Insurance _____

Member ID# _____ Group # _____ Policy # _____

Name & Address of Medical Insurance _____

Member ID# _____ Group # _____ Policy # _____

Patient Dental and Medical History

Dentist _____ Office Phone _____ Date of Last Visit _____

Have you ever had any difficult extractions in the past? YES / NO Have you ever had any prolonged bleeding following extractions? YES / NO

Physician _____ Office Phone _____ Date of Last Exam_____

1. Are you under any medical treatment now? YES NO

2. Have you been hospitalized for any surgical procedures or illness in the last 5 years? YES NO

   If yes, please explain _____

   _____

3. Are you taking any medication(s)? YES NO
   If yes, please list here. Include any non-prescription drugs taken on a regular basis.

   _____

   _____

4. Do you use tobacco? YES NO

5. Do you use controlled substances? YES NO

6. Are you wearing contact lenses? YES NO

7. WOMEN ONLY:
   Are you pregnant or think you may be ? YES / NO
   Are you nursing ? YES / NO
   Are you taking oral contraceptives? YES / NO

8. Are you allergic to, or have you had any reactions to the following:

Local Anesthetics (e.g. Novocain)	YES	NO
Penicillin or any other antibiotics	YES	NO
Sulfa Drugs	YES	NO
Barbiturates	YES	NO
Sedatives	YES	NO
Iodine	YES	NO
Aspirin or Aspirin based drugs	YES	NO
Latex Rubber	YES	NO

   OTHER _____

9. Do you have, or have you ever had any of the following?:

High Blood Pressure	YES / NO	Rheumatic Fever	YES / NO	Epilepsy / Convulsions	YES / NO
Low Blood Pressure	YES / NO	Leukemia	YES / NO	Respiratory Problems	YES / NO
Heart Disease	YES / NO	Asthma	YES / NO	Diabetes	YES / NO
Cardiac Pacemaker	YES / NO	Anemia	YES / NO	Kidney Disease	YES / NO
Heart Attack	YES / NO	Emphysema	YES / NO	Cancer	YES / NO
Heart Murmur	YES / NO	Liver Disease	YES / NO	Hay Fever / Allergies	YES / NO
Tuberculosis	YES / NO	Thyroid Problem	YES / NO	Osteoporosis	YES / NO
Stroke	YES / NO	Glaucoma	YES / NO	Stomach problems/ulcers	YES / NO
Angina	YES / NO	Radiation Therapy	YES / NO	Joint Replacement	YES / NO
Chest Pains	YES / NO	Recent Weight Loss	YES / NO	Aids or HIV Infection	YES / NO
Easily Winded	YES / NO	Fainting / Seizures	YES / NO	Clotting Problems	YES / NO

   Other _____

10. Do you have a living will or advance directive? YES / NO
11. Ethnicity:_____
12. Primary Language:_____

I certify that the above information is true, accurate and complete to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information or omitting information can be dangerous to my health.

X _____ Date _____
Signature of patient (or parent, if a minor)

Kentuckiana Oral & Maxillofacial Surgery Associates, PSC

DOWNTOWN
225 Abraham Flexner Way
Suite 302
Louisville, KY 40202
(502) 587-7874
FAX (502) 587-0758

MT. WASHINGTON
138 East Brooke Court
Suite 100
Mt. Washington, KY 40047
(502) 957-1250
FAX (502) 538-6057

SPRINGHURST
9488 Brownsboro Road
Louisville, KY 40241
(502) 326-0606
FAX (502) 326-0611

CANNONS
2800 Cannons Lane
Suite 200
Louisville, KY 40205
(502) 454-4885
FAX (502) 452-1926

Financial Responsibility Sheet

Patient Name: _____Date: _____

Basic Policy: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid drivers license), credit cards and several financing companies. We process our checks through Telecheck. These checks are processed electronically and withdrawn from your bank. There is a $50.00 returned check fee due, and payable from you for each check payment returned to Telecheck by your bank.

For Patients with Insurance: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to estimate your co-payments and deductible which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

Managed Care Participants Some benefit plans require pre-authorization and specialists referral forms from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit.

Surgery Fees: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization is required by your insurance carrier. **The tentative treatment plan represents an estimate of charges based on the findings of actual treatments.** You may receive a revised list of charges at the time of or following treatment. INSURANCE COVERAGE IS ESTIMATED. You, the patient are responsible for all financial obligations for your health care services. You will be charged a service charge each month for unpaid balances. If for some reason your account should become delinquent, you agree to pay for all rebilling charges, interest charges, collection fees and attorney costs, if necessary**. A surgery deposit is required to schedule surgery. The amount will be specified when the treatment plan is established.**

Non-Covered Charges: Any charges not paid by your insurance carrier will require payment in full at the time of service or services are provided or upon notice of insurance claim denial. To assist our patients, we offer financial arrangements and/or alternative financing sources. Please ask our billing personnel for additional information.

Minor Patients: The adult accompanying a minor is responsible for the full payment. We accept pre-arranged payment over the phone with a major credit card (American Express, MasterCard, Visa) and debit cards or cash/check when patient is accompanied by an adult who is not the parent or guardian.

Workers Compensation/Personal Injury: If the injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment. This office does not bill for lawsuit related cases. The patient is responsible for services provided at the time of service. We do not wait for payment pending suit settlement.

Cancellation of Appointments: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, we require at least 24 hours notice when canceling an appointment. If a patient "No-Shows" for an appointment you may be charged a $25.00 deposit to schedule your next appointment. This deposit is non-refundable. The practice reserves the right to dismiss patients with excessive cancelled appointments or if an appointment is missed without required 24 hour notice.

If for some reason your account should become delinquent, you agree to pay for all re-billing charges, interest charges, collections (33.3% of unpaid balance of accounts less than 1 year old) and attorney's fees if necessary. **Responsible party initials**: _____.

FAMILY MEDICAL LEAVE ACT/ WORKERS COMP. FORMS: KOMSA will complete all leave papers after a $ 20.00 administration fee is paid. We will complete the papers and mail/fax to the appropriate department. We will complete the forms within 2 business days.
These will not be filled out until surgery has been completed. _____ (**Please initial**)

Patient's Name (print) _____ Date: _____

Patient's Signature: _____ Date: _____

Guarantor: _____ Date: _____
(If other than patient)
Relation to patient: _____

Acknowledgement of Privacy Policies:

I, _____, have been offered a copy of this office's Notice of Privacy Policy Practices, required by HIPPA.

Consent for Use and Disclosure of Health Information:

I, _____, understand that I am giving my consent to your use and disclosure for my protected health information to carry out treatment, payment activities and health care operations.
If a personal representative of the patient signs this consent, please sign below:
Personal Representative's Name: _____

Relationship to Patient: _____

Release of patient records to another individual

I, _____, authorize the release of my records (doctor's notes and all test results) to _____, (patient relation) _____.

If you wish for no one, to have access your records, please indicate this in the space above. If you should have any questions, please let us know.