PATIENT

PATIENT LAST NAME	FIRST	MIDDLE	PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE
BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER		HOME PHONE ☐ NONE MESSAGE PHONE	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	
MAILING ADDRESS			CELL PHONE	CITY	STATE ZIP CODE
EMPLOYER		EMPLOYERS PHONE #			
EMERGENCY CONTACT		RELATIONSHIP	PHONE ( )	ADDRESS	
GENERAL DENTIST	PHONE #	PRIMARY CARE PROVIDER		PHONE #	

PT UNDER 18:FATHER OF PATIENT (PLEASE FILL OUT COMPLETELY)

LAST NAME	FIRST	MIDDLE		
HOME PHONE ☐SAME	SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	
HOME ADDRESS ☐SAME AS ABOVE		CITY	STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS		BUS. PHONE	OCCUPATION

PT UNDER 18:MOTHER OF PATIENT (PLEASE FILL OUT COMPLETELY)

LAST NAME	FIRST	MIDDLE		
HOME PHONE ☐SAME	SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	
HOME ADDRESS ☐SAME AS ABOVE		CITY	STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS		BUS. PHONE	OCCUPATION

STUDENT STATUS INFORMATION

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE
BOTH PARENTS NAMES	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa	

DENTAL INSURANCE ☐NONE ☐MEDICAID

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

MEDICAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

IF YOU HAVE SECONDARY DENTAL, MEDICAL OR BOTH ASK FOR FORM AT FRONT DESK.

PLEASE FILL OUT THIS FORM COMPLETELY

IF SOMETHING DOES NOT APPLY TO YOU PUT N/A IN THE BOX.

Patient Name: _____ Date: _____ Page 1

1. Are you in good health? Y N
2. What is your Height Weight
3. Has there been any change in your oral health? Y N
4. Are you under a physician's care for a particular problem? Y N
5. Have you had any serious illnesses, operations or hospitalizations? If so, please describe below:

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

6. Rheumatic fever or rheumatic heart disease Y N
7. Congenital heart disease? Y N
8. Cardiovascular disease (please circle) heart trouble, heart attack, heart murmur, coronary artery disease, mitral valve prolapse, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker?
9. Lung disease (please circle) asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?
10. Neurologic-psychological disorders (please circle) convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown?
11. Blood disease (please circle) anemia, bleeding tendency, blood transfusion, do you bruise easily? Y N
12. Liver disease? (jaundice, hepatitis) Y N
13. Kidney disease ? Y N
14. Diabetes ? Y N Are you insulin dependent? Y N
15. Thyroid disease? Y N
16. Arthritis? Y N
17. Stomach ulcers or colitis? Y N
18. Glaucoma? Y N
19. Frequent or recurring mouth sores? Y N
20. Implants placed anywhere in you body? (please circle) heart valve, hip, knee
21. Radiation (x-ray) treatment for cancer? Y N
22. Clicking or popping of jaw joints, pain near ear, difficulty opening mouth, grind or clench teeth?

23. Sinus or nasal problems? Y N

24. Any diseases, drugs or transplant operation that has depressed your immune system? Y N

25. Marijuana or "street" drugs? Y N

26. Recurrent infections of any kind? Y N Please list _____

27. Problems with anesthesia? Y N

28. Porphria? Y N

29. Problems with tooth extractions? Y N

30. Cancer? Y N If so please define: _____

31. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N If so please explain: _____

THIS SECTION IS FOR FEMALES***(MALES PROCEED TO #34)***

32. Are you taking birth control pills? Y N

33. Are you pregnant? Y N How many weeks? Are planning pregnancy? Y N

***************DENTAL HISTORY**************

34. When was your last check-up? _____

35. Were x-rays taken? Y N Did you bring a copy with you today? Y N

36. Do you have sore or sensitive teeth? Y N

37. Do you have any sores, swelling, or fever blisters in your mouth? Y N

**************MEDICATION INFORMATION **************

PLEASE LIST ANY NARCOTIC PAIN PRESCRIPTION YOU ARE CURRENTLY TAKING.

38. Are you taking any medication? Y N Please list all medications you are taking below:

_____ _____ _____ _____ _____ _____

Are you currently under the care of a pain managment facility? Y N (If yes please list name and ph#)

_____ Ph# _____

39. Are you allergic to any *medications or foods?* Y N Please list below:

_____ _____ _____ _____ _____ _____

40. Do you wish to talk to the doctor privately about anything? Y N

I have read and received a copy of the Privacy Policy and Procedures for Georgetown Oral and Facial Surgery

Hippa Acknowledgement Signature _____ Date: _____

Georgetown Oral and Facial Surgery
101 Darby Drive Suite 101
Georgetown, KY 40324
T. (502) 863-5858
F. (502) 863-5838

Financial Policy

Dental treatment is an excellent investment in an individual's physical and psychological well being. Our office is committed to providing you with the best health care possible. In order to achieve this goal, we need your assistance and understanding of our financial policy.

As a health care provider, we must emphasize that our relationship is with you, not with your dental or medical insurance company. You are ultimately responsible for your account. If you have dental or medical insurance, we will do our best to help you receive your maximum allowable insurance benefits – but we have no control over those benefits.

Additionally, financial considerations should not be an obstacle to obtaining important health care treatment. We recognize that not all of our patients have health or dental insurance. We are sensitive to your varying needs and financial obligations.

In order to better serve you, we have prepared several payment options to provide you with the flexibility that you deserve:

- ☐ Self Pay – **You are responsible for your fees at the time of service**. For your convenience, we accept cash, Visa® and MasterCard® and Discover®.
- ☐ Dental Insurance – **You and your insurance company share responsibility for your fees and your portion is due at the time of service**.

  We will submit your claim and receive payment from your insurance company for services provided. We will contact your insurance carrier on your behalf so that we may provide you with an **estimate** of the portion of your fees due at the time of service. You must realize, however, that all charges are ultimately your responsibility. Most dental insurance plans do not cover all services in full. We cannot be held responsible if in fact there is no insurance coverage for the procedure(s), or if your insurance company refuses payment at a later date. Furthermore, some portion or all of your benefits may be used for the plan year.

  Care Credit – **You are responsible for your fees at the time of service and you finance those fees with Unicorn Financial with no initial payment. Care Credit pays Georgetown Oral and Facial Surgery on your behalf for services rendered and you pay Care Credit monthly payments.**

Please note: In addition to all outstanding balances the patient acknowledges and agrees to pay all reasonable collection fees and legal fees.

Signature:_____

Date:_____

MEDICAL INFORMATION RELEASE FORM

GEORGETOWN ORAL AND FACIAL SURGERY
DR ROBERT HENDERSON
101 DARBY DRIVE SUITE 101
GEORGETOWN KY 40324

Patient Name:_____

Patients Signature:_____Date:_____

Release of Information

I authorize the release of my private healthcare information to the following person(s). This information will include diagnosis, records, radiology reports and financial records.

( ) _____
Please Print Name Relationship to Patient

( ) _____
Please Print Name Relationship to Patient

( ) _____
Please Print Name Relationship to Patient

( ) Information is not to be released to anyone.

You do not have to list a parent or guardian for minor children except in cases of divorced parents where this is stated in a divorce decree.

This Release of Information will remain in effect until terminated by me in writing.

GEORGETOWN ORAL & FACIAL SURGERY
Dr. Robert Henderson
101 Darby Drive, Suite 101
Georgetown, KY 40324
Phone: 502-863-5858

Bisphosphonates Form

Have you ever been diagnosed with the following conditions:

Metastatic Cancer, Breast Cancer, Bone Cancer or Osteoporosis: Yes_____ No_____

Have you ever taken the following medications and if so please circle which of the following:

Medication	Generic Version
Fosamax	Alendronate
Zometa	Zoledronate
Reclast	Zoledronic Acid
Boniva	Ibandronate
Aclasta	Zoledronic Acid
Didronel	Etidronate
Actonel	Risedronate
Aredia	Pamidronate
Atelvia	Risedronate
Binosto	Alendronate
Skelid	Tiludronate

When was the last time this medication was taken? _____

Signature: _____ Date: _____