NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

PATIENT INFORMATION RECORD **Today's Date: 9/17/2014**

Legal Name of Patient: _____
Last First Middle Nickname

Address: _____ **City:** _____ **State:** _____ **Zip:** _____«apzip»_

Phone/Home: _____ **Cell:** _____ **SSN:** _____

Age: _____ **Gender:** ❒M ❒F **Date of Birth:** _____

School (If Student): _____ **Email:** _____

Employer: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Work Phone: _____ **Occupation:** _____

Marital Status: **S** ❒ **M** ❒ **D** ❒ **W** ❒ **Spouse Name:** _____

Spouse Employer: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** ____

RESPONSIBLE PARTY -
Who is responsible for this account? **Parent** ❒ **Guardian** ❒ **Self** ❒ **Email:** _____
Name: _____ **Drivers License #:** _____
Address: _____ **City:**_____ **State:** _____ **Zip :**___
Employer: _____ **Employer Phone:** _____

INSURANCE INFORMATION-Please present <u>all</u> insurance cards to receptionist for scanning.
Primary
Insured Name: _____ **Date of Birth:** _____
Last First Middle
Dental Insurance Co: _____
Medical Insurance Co: _____

Secondary
Insured Name: _____ **Date of Birth:** _____
Last First Middle
Dental Insurance Co: _____
Medical Insurance Co: _____

As a service to our patients we will submit a claim form to your insurance(s) for reimbursement. This assistance is not a guarantee of payment for services by the insurance company. <u>Any charges incurred are payable by the patient &/or the responsible party</u>. My signature authorizes payment directly to the dentist of the group, insurance benefits otherwise payable to me; and authorizes release of any information relating to any claim.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ **Date:** _____

NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

HEALTH QUESTIONNAIRE

Date: _____

Patient Legal Name: _____ **Referred by:** _____

Age: _____ **Date of Birth:** _____

1. Why are you here? _____

2. Are you in pain? _____ **How long?** _____

3. Who is your regular dentist? _____

4. Who is your medical doctor? _____

5. Who is your orthodontist? _____

	YES	NO
6. Are you sensitive or allergic to any drugs? Please list:	____	____
Aspirin, Codeine, Penicillin, Other: _____		
7. Are you taking any medicines regularly? Please list on medication sheet.	____	____
8. Have you been under the care of a physician in the last (5) years?	____	____
9. Have you been treated for depression, anxiety, or a psychiatric condition?	____	____
10. Have you ever had orthodontic treatment (Braces/Appliances)?	____	____
11. Have you ever had an injury to your teeth or jaws?	____	____
12. Do you have or have you ever been treated for TMJ problems?	____	____
13. Have you ever had surgery?	____	____
Please list your surgeries and the date: _____		
14. Have you ever had general anesthesia?		
Please describe any problems? _____		
15. Do you wear contact lenses?	____	____
16. Do you use tobacco?	____	____
17. Do you use alcohol?	____	____
18. Have you used street drugs in the past year?	____	____
19. Do you or have you used diet drugs?	____	____
20. Do you take herbal supplements?	____	____
21. Are you pregnant or nursing?	____	____
22. Do you take birth control pills?	____	____
23. List any other condition:		
_____		
24. Do you wish to talk with the doctor about anything privately?	____	____

NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

HEALTH QUESTIONNAIRE

Patient Legal Name:_____ **DOB:** _____

PLEASE MARK AN "X" IN THE APPROPRIATE SPACE

YES	NO		YES	NO	
____	____	Rheumatic fever	____	____	Lung problems
____	____	Congenital heart defect	____	____	Asthma
____	____	Heart murmur	____	____	Emphysema/COPD
____	____	Heart surgery	____	____	Pneumonia
____	____	Heart attack	____	____	Tuberculosis
____	____	Heart condition (i.e. pacemaker, angina, stent)	____	____	Diabetes (circle) Type: I II
____	____	Mitral valve prolapse	____	____	Hepatitis: (circle) A B C
____	____	High/Low blood pressure	____	____	Liver disease
____	____	Bleeding problems	____	____	Kidney disease
____	____	Anemia	____	____	Thyroid disease
____	____	Bruise easily	____	____	Glaucoma
____	____	Birth defect	____	____	Nasal problems
____	____	Seizures/Epilepsy	____	____	Gum disease
____	____	Psychiatric treatment (anxiety/depression)	____	____	Mouth sores
____	____	Stroke (CVA)	____	____	Cancer
____	____	Artificial joint (i.e. hip, knee)	____	____	Radiation treatment
____	____	Orthopedic plates &/or screws	____	____	Chemotherapy
____	____	Arthritis	____	____	Venereal disease
____	____	Cortisone treatment	____	____	Immune disorder
____	____	Cortisone treatment	____	____	HIV positive

To the best of my knowledge, all of the preceding answers are true and correct. I acknowledge that if I am having surgery with intravenous conscious sedation, I understand and agree that my driver will remain in the office during my surgery. I have had an opportunity to discuss my health history and any questions I may have with my doctor.

9/17/2014 _____
Date Patient's signature OR parent/guardian, if the patient is a minor

HEALTH HISTORY UPDATE

_____
_____
_____

_____
Date Patient's signature OR parent/guardian, if the patient is a minor

NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

MEDICATION SHEET

Patient Legal Name:_________________________________ **DOB:** ___________________________

Drug allergies (please list): ____

____

Date	Current Medications, Vitamins, Herbal Supplements	Rx by

NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

HIPPA

Patient Acknowledgement and Consent Form

Effective April 14, 2014 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that this office comply with certain rules regardless the maintenance of the privy of your information that we have collected and will collect in the future.

To comply with one of HIPPA's requirements, we are giving you the opportunity to take a copy of pure Notice of Privacy Practices (please ask if you'd like a copy). This notice will contain the information that HIPPA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (on addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fee; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make discloser of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment
Please sign this form below under the heading "acknowledgment" to acknowledge that you have been offered and/or received a copy of our Notice of Privacy Practices.

I acknowledge that I have been offered a copy and/or have received of the Notice of Privacy Practices.

Patient/Legal Guardian Signature Printed Name of Signer Date

For office use only:
Patient refused to sign due to the following circumstances:

☐ An emergency situation prevented the patient from signing the Acknowledgement.

Signature of Office Personnel Printed Name of Signer Date

Patient Consent
Please sign this form under the heading "Consent" to consent to our disclosures of your information that we may deem necessary in order to provide you with proper treatment.

I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosure may be of the type listed above, and those listed in your Notice of Privacy practices.

NORTHERN MICHIGAN ORAL & MAXILLOFACIAL SURGERY, P.C.
James J. Osetek, D.M.D.

FINANCIAL POLICY

An explanation of fees before surgery is helpful to all concerned. We will provide you with an estimate for your treatment. ***Please remember, it is only an estimate.***

If you have NO dental or medical insurance: You are responsible for full payment on the date of service for the treatment rendered.

If you have dental insurance: We will bill your services to your insurance as a courtesy to you. Every insurance carrier is different, and it is recommended that you check with your carrier to determine your level of coverage before undergoing surgery. Any benefits paid by your dental insurance, should be paid to the subscriber. However, the payment may not be the same as our fees. If you wish to have a predetermination of benefits obtained from your insurance carrier, please ask. We will submit a predetermination to your insurance carrier on your behalf.

If you are a **Delta Dental of Michigan** (Premiere or PPO Program) subscriber, you are responsible for any non-covered services, deductible, or co-payment on the date of service. If you wish to have a predetermination of benefits obtained from your insurance carrier, please ask. We will submit a predetermination to your insurance carrier on your behalf.

If you have medical insurance: It may be required that we bill them before your dental plan will consider the claim for benefits. Please present both your dental and medical insurance information (cards) at the time of your appointment. Some medical insurances require a referral and/or an authorization from your primary care physician. You are responsible for contacting your primary care physician (PCP) office and obtaining the paperwork needed for each visit. Failure to provide all the insurance information or obtain this authorization may require postponement of your visit and/or result in non-payment, or reduction in the payment, for your procedure.

AUTHORIZATION AND CONSENT

Authorization to bill dental and/or medical insurance: I hereby authorize Northern Michigan Oral and Maxillofacial Surgery, P.C. to furnish information to my insurance company concerning my care.

_____ _____
Date Signature of Patient/Parent/Guardian

Consent to pay for services rendered: ***I understand that I am responsible for full payment on the date treatment is rendered.***

_____ _____
Date Signature of Patient/Parent/Guardian