East Louisville Oral Surgery and Dental Implants, PLC.

ORAL & MAXILLOFACIAL SURGERY

KENNETH W. LIVESAY, JR., D.M.D.
THOMAS BAILEY, D.M.D.

PATIENT REGISTRATION (Please Print)

Please Fill Out Completely

Patient's Name: First ______ Initial ______ Last ______ Have you been a patient here before? ______

Street Address ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone (parent if minor) (   ) ______ Employer ______

Date of Birth ______ Cell Phone ______

Email Address ______ Social Security # ______

Spouse's Name (parent if minor) ______ Spouse's Social Security # (parent's if minor) ______

Your Dentist ______ Your Orthodontist ______

Referred by ______ Your Physician ______

Who is with you today? ______ Their relationship to you? ______

Have any relatives been treated by us? ______

Their name and relationship ______

INSURANCE INFORMATION

THE FOLLOWING INFORMATION IS FOR THE EMPLOYEE WITH PRIMARY INSURANCE:

Name of Employee ______ S.S. # of Employee ______ Relationship to Patient ______ Birthdate of Empl. ______

Dental Insurance Company Name & Phone # ______ Employer Name ______ Work Phone (   ) ______

Medical Insurance Company Name & Phone # ______ Address of Employer ______ City ______ State ______ Zip ______

THE FOLLOWING INFORMATION IS FOR EMPLOYEE WITH SECONDARY INSURANCE:
(ANY POLICY PROVIDING MORE COVERAGE AFTER PRIMARY PAYS)

Name of Employee ______ S.S. # of Employee ______ Relationship to Patient ______ Birthdate of Empl. ______

Dental Insurance Company Name & Phone # ______ Employer Name ______ Work Phone (   ) ______

Medical Insurance Company Name & Phone # ______ Address of Employer ______ City ______ State ______ Zip ______

I authorize payment of medical or dental benefits directly to Dr. Livesay for the services: ______ **SIGNATURE OF EMPLOYEE** ______ **DATE**

I authorize the release of any medical information necessary to process insurance claims: ______ **SIGNATURE OF PATIENT OR PARENT** ______ **DATE**

I agree to pay East Louisville Oral Surgery & Dental Implants, PLC for any and all services rendered and expenses incurred by the patient. I, as the responsible person on this account, understand that bills are payable in full upon rendering treatment. Delinquent accounts will be turned over to a collection agency. I further agree that, in the event legal action is required in order to enforce payment on this account, I will pay court costs, expenses, attorney fees and other costs incurred and / or expended as a result of such proceedings.

I assign to East Louisville Oral Surgery & Dental Implants, PLC all benefits due me for treatment under an applicable policy of Insurance. I understand that I am financially responsible to East Louisville Oral Surgery & Dental Implants, PLC for all charges and services not covered by this assignment and promise to pay any remaining balance.

This office extends a 60 day grace period for payment of all fees to allow time for insurance payments. I understand that all fees still outstanding after 60 days from date of treatment are past due and will incur a $1^1/_2$ % per month charge (18% per Annum) for rebilling regardless of whether insurance is still pending.

Signature ______ **Date** ______

If different from patient: ______ Complete Address with street, city, state, and zip, home and work phones, social security number

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MEDICAL HISTORY FORM

Name:____________________________ Date:____________________________

Date of Birth: ______________ Age: _______ Sex: M / F Height:________Weight: ___________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?.. Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on __________/_____/_____
4. Are you now under the care of a physician?.. Yes No
   If so, for what condition? ____
5. The name and phone # of my physician is:___________________________________
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No
   Please explain: ____
   ____
7. Have you had an artificial joint replacement (knee, hip, etc.)? What year? .... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? **Please circle one if yes** .... Yes No

9a. Are you taking any blood thinners? (Xarelto,Coumadin,Plavix,Pradaxa,Aggrenox,Aspirin)
Please circle one if yes____

9b. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? .... Yes No
If so, please list: ____
____
____
____
____

10. Do you have or have you had any of the following diseases or problems? **If yes, please explain**
    a. Artificial valves, heart murmur, or mitral valve prolapse .... Yes No
    b. Rheumatic Heart Disease, damaged heart valves .... Yes No
    c. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition .... Yes No
       1. Chest pain upon exertion?... Yes No
       2. Shortness of breath after mild exercise? .... Yes No
       3. Do your ankles swell?.. Yes No
    d. High Blood Pressure.. Yes No
    e. Sinus trouble .... Yes No
    f. Asthma .... Yes No
    g. Fainting spells or seizures.. Yes No
    h. Diabetes .... Yes No
    i. Hepatitis, jaundice or liver disease.. Yes No
    j. Frequent or recurring mouth sores... Yes No
    k. Thyroid problems .... Yes No
    l. Respiratory problems, emphysema, bronchitis, COPD ,etc. .... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ).. Yes No

n. Osteoporosis .... Yes No
o. Stomach ulcer or colitis .... Yes No
p. Kidney disease .... Yes No
q. Tuberculosis .... Yes No
r. Persistent cough or cough that produces blood .... Yes No
s. Persistent swollen neck glands .... Yes No
t. Low blood pressure .... Yes No
u. Epilepsy or neurological disorder .... Yes No
v. Cancer .... Yes No
w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No

11. Have you had abnormal bleeding? .... Yes No
a. Have you ever required a blood transfusion? .... Yes No

12. Do you have any blood disorder such as anemia? .... Yes No

13. Have you ever had treatment for a tumor or growth? .... Yes No

14. Have you had radiation therapy to the head, neck or jaws? .... Yes No

15. Are you allergic to or have you had a reaction to:
a. Local anesthetics .... Yes No
b. Penicillin or antibiotics .... Yes No
c. Sulfa drugs .... Yes No
d. Barbiturates or sleeping pills .... Yes No
e. Aspirin .... Yes No
f. Iodine .... Yes No
g. Codeine or other narcotics .... Yes No
h. Latex or rubber products .... Yes No
i. Other **(please list name of medication)** .... Yes No

16a. Have you had any serious trouble associated with previous dental treatment? .... Yes No
If so, explain:____

____

16b. Have you or an immediate family member had any problems associated with Intravenous anesthesia………………………………………………………………………… Yes No

17. Do you have any other condition or disease you think the doctor should know about? .... Yes No
If so, explain:____

18. Do you smoke or chew Tobacco? .... Yes No
How much? ___________________________ How long ?_________________________

19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? .... Yes No

20. Are you wearing contact lenses? .... Yes No

21. Are you wearing removable dental appliances? .... Yes No

22. Do you wish to talk with the doctor privately about anything? .... Yes No

23. Were you planning to be asleep for your Oral Surgery procedure? ………………………….Yes No

Women

24. Are you pregnant or any chance you might be pregnant? .... Yes No

25. Are you nursing? .... Yes No

26. Are you taking birth control pills? (If so, antibiotics and some other medications may interfere with the effectiveness of birth control. Consult with your physician.) .... Yes No

Chief Dental Complaint: ____

____

____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:__________________ Patient's Signature:____

Acknowledgement of Receipt of Notice of Privacy Policies

I have received the Practice's Notice of Privacy and understand that my protected health information may be used by the Practice as described in the notice.

____
(Print) Patients Name

____ _______________
Signature of patient or parent **Date**

East Louisville Oral Surgery and Dental Implants, PLC can leave a message on:

Cell Phone:_____________________________________

Home Phone:_____________________________________

Work Phone:_____________________________________

Information Release to a Third Party

To: East Louisville Oral Surgery and Dental Implants, PLC

From: ____

RE: **Information Release Authorization**

I hereby authorize you to release the information in my medical records to the following person or organization:

____

I understand that the information may include other information regarding my physical condition including, but not limited to, diabetes, drug abuse, alcoholism, etc. if any, if these conditions are part of my record.
Specific Information requested:

________X-rays ________Charts ________Treatment Other______________

Reason for request:

Second Opinion________ Transfer________ Other______________________
This authorization is limited to the release of information to the person or organization named and to no others, I understand that this consent authorization will expire when the information has been released or when it has been revoked by me. I will pay the cost, if any, for the transmission of the information requested.
Patient Signature: __________________________________

Witness Signature: _________________________________