

PATIENT REGISTRATION & INSURANCE INFORMATION
DR. ROBERT S. KIKEN
ORAL & MAXILLOFACIAL SURGERY

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date: _____

Sex: _____ Age: _____ Date Of Birth: _____ Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ Spouse's Name: _____

Referring Dentist: _____ Orthodontist: _____

Reason for Visit: _____

RESPONSIBLE PARTY

Responsible Party's Name: _____

Social Security #: _____ Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone #: _____

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

INSURANCE

Name of Insurance Plan: _____

Subscribers Name: _____ Subscriber I.D.: _____

Subscribers D.O.B.: _____ Subscribers Phone: _____

Subscribers Address (if different than above): _____

MEDICAL HISTORY FORM
DR. ROBERT S. KIKEN
ORAL & MAXILLOFACIAL SURGERY

Name: _____

Date: _____

Date of Birth: _____

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 address of my physician is: _____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? 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 or Zometa) ? Yes No
9. 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?
 - a. Damaged heart valves, artificial valves or heart murmur..... Yes No
 - b. Rheumatic Heart Disease..... Yes No
 - c. Heart trouble, heart attack, angina, high blood pressure, 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. Allergies..... Yes No
 - e. Sinus trouble..... Yes No
 - f. Asthma or hay fever 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, etc..... Yes No
 - m. Arthritis or painful, swollen joints including jaw joint (TMJ)..... Yes No
 - n. Osteoporosis Yes No
 - o. Stomach ulcer or hyperacidity Yes No
 - p. Kidney trouble..... 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 pressureYes No
- u. Epilepsy or neurological disorderYes No
- v. CancerYes No
- w. Any disease, drug or transplant operation that has depressed your immune systemYes 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 anestheticsYes No
- b. Penicillin or antibioticsYes No
- c. Sulfa drugsYes No
- d. Barbiturates or sleeping pillsYes No
- e. AspirinYes No
- f. IodineYes No
- g. Codeine or other narcoticsYes No
- h. Latex or rubber productsYes No
- i. Intravenous anesthesiaYes No
- j. OtherYes No
16. Have you had any serious trouble associated with previous dental treatment?Yes No
- If so, explain: _____
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? _____
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

Women

20. Are you pregnant or trying to become pregnant?Yes No
21. Do you have problems associated with your menstrual period?Yes No
22. Are you nursing?Yes No
23. Are you taking birth control pills?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.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION
DR. ROBERT S. KIKEN
ORAL & MAXILLOFACIAL SURGERY

Patient's Name _____ Date of Birth: _____

SSN: _____ Previous Name _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

- 1) Signing and dating a form that my doctor and his staff can give me called "Revocation of Consent for Use and Disclosure of Health Information", or
- 2) Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice." If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices". My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

Patient (or legally authorized individual) signature

Date

Relationship to patient (parent, legal guardian, etc.)

**POLICY REGARDING INSURANCE
DR. ROBERT S. KIKEN
ORAL & MAXILLOFACIAL SURGERY**

For our patients who have INDEMNITY CARRIERS AND REIMBURSEMENT PROGRAMS:

We will bill your insurance as a courtesy to you. However, it must be clearly understood that the contract is between you and your insurance company, and you are fully responsible for any amount not paid by your insurance.

Our office does not guarantee that your insurance will pay. We will perform our routine insurance billing procedures but, if for some reason your insurance claim is denied, **you are responsible for the full balance of your bill within 30 days of notice of denial**

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

It is important for you to know that if we have not received payment from your insurance company within 90 days of billing, the balance becomes your responsibility.

Remember, the insurance agreement is between you and your insurance company, and you will be expected to deal with your insurance company directly if a problem should arise.

For our patients who have HMO or DMO coverage:

We are preferred providers and have agreed to approved fees for those services under our agreement with the carrier. We are only authorized to perform those services agreed upon. Should you and our office mutually decide to perform and receive services outside our contract with the carrier, you will be responsible for payment of the fees.

Your co-payment is due on the day of surgery. This is your responsibility and obligation.

I have read and agree to the terms as outlined above.

Signature: _____ Date: _____