GREAT PLAINS
ORAL & MAXILLOFACIAL SURGERY, PA

Today's Date _____

PATIENT INFORMATION

First Name _____ M.I._____ Last Name _____ Nickname _____

Sex ☐F ☐M Birth Date _____ Age_____ S.S. # _____ Home #_____

Cell # _____ Email _____ Driver's Lic # _____

Street _____ Apt _____ City_____ State _____ Zip _____

Employer _____ Occupation _____ Referred by _____

PHYSICIANS

Medical Doctor _____ General Dentist _____

Other _____ Other _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

Age 18 and over is "Self"

☐Self (*If self, skip to next section*) ☐Father ☐Mother ☐Other _____

First Name _____ Last Name _____ S.S.# _____ Birth Date _____ Age _____

Cell # _____ Email _____ Driver's Lic # _____ Employer _____

Street _____ Apt _____ City_____ State _____ Zip _____

RELEASE OF INFORMATION

By providing this information, I authorize Great Plains OMS, PA to release information to the persons listed below:

☐ ACCOUNT – Billing and Insurance Name(s) _____ _____

☐ TREATMENT – Radiographs, Treatment Name(s) _____ _____

☐ HEALTH/MEDICAL – Health/Medical History Name(s) _____ _____

INSURANCE / PAYMENT INFORMATION

Marital Status	☐ Married	☐ Divorced	☐ Legally Separated	☐ Widowed	☐ Single
In whose name is this insurance (Subscriber)?		☐ Mine	☐Spouse	☐ Partner	☐ Parent
Employment Status	☐ Full Time	☐ Part Time	☐ Retired	☐ Not	
Personal Payment Type	☐ Cash	☐ Check	☐ Credit Card	☐ Care Credit	☐ FSA/HSA

PRIMARY DENTAL INSURANCE INFORMATION

Employer _____

Insurance Co. Name _____

Claims Address _____

Phone # _____ ID # _____

Group Name or # _____

Insured Party *(if different from patient or Account Responsible Party)*

First Name _____ Last Name _____

Sex ☐F ☐M Birth Date _____ S.S. # _____

PRIMARY MEDICAL INSURANCE INFORMATION

Employer _____

Insurance Co. Name _____

Claims Address _____

Phone # _____ ID # _____

Group Name or # _____

Insured Party *(if different from patient or Account Responsible Party)*

First Name _____ Last Name _____

Sex ☐F ☐M Birth Date _____ S.S. # _____

SECONDARY DENTAL INSURANCE INFORMATION

Employer _____

Insurance Co. Name _____

Claims Address _____

Phone # _____ ID # _____

Group Name or # _____

Insured Party *(if different from patient or Account Responsible Party)*

First Name _____ Last Name _____

Sex ☐F ☐M Birth Date _____ S.S. # _____

SECONDARY MEDICAL INSURANCE INFORMATION

Employer _____

Insurance Co. Name _____

Claims Address _____

Phone # _____ ID # _____

Group Name or # _____

Insured Party *(if different from patient or Account Responsible Party)*

First Name _____ Last Name _____

Sex ☐F ☐M Birth Date _____ S.S. # _____

PATIENT HEALTH HISTORY

Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Please answer all questions completely and accurately. If you have any questions regarding answering specific items on this questionnaire, please ask one of our staff for assistance. Thank you.

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE	Y	N	NOTES/YEAR
Contact Lenses			
Glaucoma			
Sinus Problems			
Skin Diseases/Disorders			
Sleep Apnea			
TMJ Pain			
Epilepsy			
Seizures			
Psychiatric Care			
Anemia			
Blood Clotting Diseases/Disorders			
Blood Transfusions			
Cancer			
Chemotherapy			
History of Blood Clots			
Malignant Hyperthermia			
Radiation			
Sickle Cell Anemia			
Arthritis			
Gout			
Diabetes			
Dialysis			
Kidney/Bladder Diseases or Transplant			
Lengthy Steroid Treatment			
Low Blood Sugar			
Thyroid Disorders/Adrenal Diseases			
Asthma			
Bronchitis			
Emphysema			
Artificial Joints			
Prosthetic Heart Valves			
Cardiac Stents			
Coronary Bypass			
Endocarditis			
Heart Attack			
Heart Murmurs			
High Blood Pressure			
Irregular Heartbeat			
Pacemaker			
Rheumatic Fever			
Stroke			
Chron's Disease			
Hepatitis			
HIV/AIDS			
Liver Disease			
Stomach Ulcers			
Ulcerative Colitis			

Do you have any medical issues not listed? ☐Yes ☐No If yes, explain:

_____

_____

_____

Allergies or reactions to medications or Latex Local Anesthesia Eggs Soy

Other: _____

_____

HAVE YOU USED, OR DO YOU CURRENTLY USE ANY OF THESE MEDICATIONS	Y	N	NOTES
Blood Thinning Medications			
Aspirin			
Aggrenox (Dipyridamole)			
Coumadin (Warfarin)			
Effient (Prasugrel)			
Eliquis (Apixaban)			
Lovenox (Enoxaparin)			
Pentoxifylline (Trental, Pentroxil)			
Plavix (Clopidogrel)			
Pradaxa (Dabigatran)			
Xarelto (Rivaroxahan)			
Other Not Listed:			
Osteoporosis Medications			Length of time used
Oral or Injected			
Actonel (Risedronate)			
Aredia (IV Pamidronate)			
Benofos (Clodronate)			
Boniva (Ibandronate)			
Didronel (Etidronate)			
Fosamax (Alendronate)			
Prolia/Xgeva (Denosumab)			
Reclast (IV Zoledronic Acid)			
Skelid (Tiludronate)			
Zometa (IV Zoledronate)			
Other Not Listed:			
Family History – Immediate Members			Family Member
Heart Disease/Heart Attacks			
Congenital Heart Problem			
Hypertension			
Stroke			
Bleeding/Clotting Disorder			
Diabetes			
Genetic Disorders			
Cancer			
Malignant Hyperthermia			
Anesthesia Complications			

Medications – Prescriptive and non-prescriptive

Medication	Dosage (mg/pill)	Frequency

Surgical History (Please list ALL surgeries with dates)

Surgery/Procedure	Date

PATIENT HEALTH HISTORY - continued

SOCIAL HISTORY Have you used, or do you currently use?	Y	N	# Drinks/week # Packs/day	How many years?
Alcohol				
Tobacco/Vape				
Marijuana				
History of Illicit Drug Use				

WOMEN ONLY	Y	N	NOTES
Are you currently pregnant or nursing?			
Are you taking birth control pills?			

PAIN MANAGEMENT	Y	N	NOTES
Are you under the care of a physician for pain management?			
Are you recovering from drug addiction?			
Current Pain Management Medications			
Methadone			
Suboxone			
Oxycodone			
Fentanyl			
Other:			

To the best of my knowledge, I have answered every question completely and accurately. I acknowledge that any omission in my health history/medication may have an effect on my oral surgery treatment.

Patient (Parent/Legal Guardian) Signature _____ Date _____

FINANCIAL AGREEMENT

In return for services provided to the patient by Great Plains OMS, PA, payment is due at the time service is rendered. This includes co-payments, deductibles, and payment for non-covered services. Payment for surgeries are due before surgery is provided. Account balances including unpaid insurance amounts are the responsibility of the patient/parent. Any remining balance 60 days after date of service regardless of insurance status is considered past-due.

FEES, PAYMENTS, AND FINANCING

Great Plains OMS, PA accepts payment via cash, check, American Express, Discover, MasterCard, and Visa. Extended payment options are available through CareCredit and must be secured prior to treatment. Treatment estimates are based on the information available at the time of estimate and may differ from the final cost based on actual treatment rendered.

Past-due accounts may be subject to interest and may be forwarded to an agency for collections. The costs of collections, attorney fees, and court costs will be paid by the responsible party.

INSURANCE

Great Plains OMS, PA files dental claims to most insurances whether considered in or out of network. Factual information and radiographs necessary to process your claim(s) will be provided to the insurance carrier. Disputes, lack of payment, downgrades, deductibles, covered charges, co-payments, discounts, secondary insurance, etc. are between you and your insurance company regardless of pre-treatment estimates. Any remaining balance unpaid by the insurance carrier is the responsibility of the patient and is due within 60 days following treatment date. There is no guarantee of payment from insurance companies, for such reason it is your responsibility to keep your account current and satisfy any unpaid balances.

This office is not contracted with Medicare, Medicaid, or any medical insurances; payment in full is due day of surgery for patients with these insurances. In the event filing to medical insurance becomes necessary, payment is due from the patient to Great Plains OMS, PA the day of surgery. We will file a dental claim to your medical carrier, and any payment made will be sent directly to the you. When a medical coverage denial is required prior to dental insurance making payment, Great Plains OMS, PA will file the medical claim, and it is the patient's responsibility to provide the denial letter to our office for forwarding to dental insurance. Until this is received, and after final payment from dental insurance, any remaining amount is the responsibility of the insured.

AUTHORIZATION

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Great Plains OMS, PA, of the benefits otherwise payable to me.

Patient/Parent/Legal Guardian _____ Date _____

A copy of HIPAA Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions about it.

Patient/Parent/Legal Guardian _____ Date _____

I authorize the doctor, other dentists, and their team members to perform diagnostic procedures and treatment as necessary for proper dentofacial care. I authorize the taking of photos, radiographs, and other diagnostic records before, during, and after treatment. I authorize Great Plains OMS, PA to release any information (via mail, fax, or electronic) including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such dental/medical care to third party payors and other entities and/or health practitioners.

Patient/Parent/Legal Guardian _____ Date _____