MID-MICHIGAN ORAL SURGERY

TODAY'S DATE:_____
UPDATED:_____
UPDATED:_____

PATIENT INFORMATION:

PATIENT NAME:_____ PHONE:_____
ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
ALT. ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
SSN:_____ AGE:_____ DOB:_____ SEX: M F MARRIED:_____ SINGLE:_____
EMPLOYER:_____ PHONE NUMBER:_____
DENTIST:_____ OTHER DENTIST (ORTHO, ENDO, ETC): _____
REFERRED BY:_____ FAMILY PHYSICIAN:_____
DO YOU HAVE XRAYS WITH YOU: YES NO DO YOU HAVE A REFERRAL SLIP WITH YOU: YES NO

DENTAL INSURANCE: PLEASE PROVIDE CARDS IF AVAILABLE

INSURANCE NAME:_____ PHONE: _____ GROUP#:_____
ADDRESS:_____ CONTRACT#:_____
INSURED'S NAME:_____ DOB:_____ RELATION TO PT:_____
INSURED'S EMPLOYER:_____
INSURED'S ADDRESS (if different):_____

SECONDARY INSURANCE:

INSURANCE NAME:_____ PHONE: _____ GROUP#:_____
ADDRESS:_____ CONTRACT#:_____
INSURED'S NAME:_____ DOB:_____ RELATION TO PT:_____
INSURED'S EMPLOYER:_____
INSURED'S ADDRESS (if different):_____

PRIMARY MEDICAL INSURANCE:

INSURANCE NAME:_____ PHONE: _____ GROUP#:_____
ADDRESS:_____ CONTRACT#:_____
INSURED'S NAME:_____ DOB:_____ RELATION TO PT:_____
INSURED'S EMPLOYER:_____
INSURED'S ADDRESS (if different):_____

SECONDARY MEDICAL INSURANCE:

INSURANCE NAME:_____ PHONE: _____ GROUP#:_____
ADDRESS:_____ CONTRACT#:_____
INSURED'S NAME:_____ DOB:_____ RELATION TO PT:_____
INSURED'S EMPLOYER:_____
INSURED'S ADDRESS (if different):_____

IF UNDER AGE 18 OR POWER OF ATTORNEY:

PARENT OR LEGAL GUARDIAN:_____ DOB:_____
SSN:_____ PHONE:_____ WORK PHONE:_____
EMPLOYER:_____

PLEASE COMPLETE ATTACHED PAGES

PATIENT NAME:_____ **DOB:**_____

DATE:_____ **UPDATED:**_____ **UPDATED:**_____

MEDICATIONS (including birth control):_____

_____

HAVE YOU EVER TAKEN ANY BISPHOSPONATE DRUGS SUCH AS: (please circle) FOSAMAX, ACTONEL, BONIVA, AREDIA, ZOMETA, RECLAST, PROLIA, NEXAVAR, AVASTIN, RAPAMUNE? YES NO WHEN:_____

DO YOU TAKE A BLOOD THINNER (other than aspirin)? YES NO MEDICATION:_____

DID YOU STOP THIS MEDICATION FOR THIS APPOINTMENT? YES NO WHEN?:_____

ALLERGIES OR DRUG SENSITIVIES:_____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

	YES	NO		YES	NO
HEART MURMUR	____	____	FACIAL NUMBNESS	____	____
HEART PROBLEMS	____	____	DIABETES	____	____
HEPATITIS/LIVER DISEASE	____	____	RHEUMATIC FEVER	____	____
HIGH BLOOD PRESSURE	____	____	ANEMIA	____	____
LOW BLOOD PRESSURE	____	____	BLOOD DISORDER	____	____
STROKE	____	____	STD	____	____
KIDNEY DISEASE	____	____	AIDS/HIV POSITIVE	____	____
TMJ	____	____	IRRADIATION THERAPY	____	____
JAW LOCKING/CLICKING	____	____	CURRENTLY PREGNANT	____	____
BLEED EXCESSIVELY	____	____	SMOKER	____	____
SEIZURES/EPILEPSY	____	____	DEPRESSION	____	____
FAINTING/DIZZINESS	____	____	ASTHMA	____	____
NERVOUS DISORDER	____	____	EMPHYSEMA	____	____
CONVULSIONS	____	____	CHRONIC COUGH	____	____
GLAUCOMA	____	____	PNEUMONIA	____	____
ALCOHOL/DRUG DEPEND.	____	____	TUBERCULOSIS	____	____

HEIGHT _____ WEIGHT _____

DO YOU HAVE A HISTORY OF CANCER? YES NO

EXPLAIN:_____ DATE:_____

MEDICATIONS TAKEN FOR TREATMENT:_____

DO YOU HAVE ANY ARTIFICIAL JOINTS OR IMPLANTS? YES NO

EXPLAIN:_____

ARE THERE ANY OTHER MEDICAL, MENTAL, OR PSYCHOLOGICAL CONDITIONS NOT LISTED? YES NO

EXPLAIN:_____

HAVE YOU USED ANY RECREATIONAL DRUGS OR ALCOHOL WITHIN THE PAST 72 HOURS? YES NO

EXPLAIN:_____

MID-MICHIGAN ORAL SURGERY

Dr. Mark E. Beckman • Dr. Vincent V. Benivegna

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been given access to this office's Notice of Privacy Practices.

Signature _____ Date: _____

Release of Medical Records

_____ I do not give permission for my medical records to be released to anyone other than myself.

_____ Your office may release my medical information to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you are being sedated for your appointment, who is driving you home after surgery?

Name: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Work Phone: _____

Signature _____ Date: _____

1040 Charlevoix Drive
Grand Ledge, MI 48837
517-627-4088

325 West Lake Lansing Road
East Lansing, MI 48823
517-337-9759

110 North Cochran Road
Charlotte, MI 48813
517-543-5150

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Your Financial Responsibility

I authorize the release of any insurance information necessary to process my claim to Mid-Michigan Oral Surgery, P.C. and payment of benefits to be made to their office for services rendered. I assume responsibility for all charges incurred and understand that I am ultimately responsible for payment of services that are rendered to me. I understand that I must be prepared to pay any/all balance due on my account after 60 days. If I do not have insurance to cover my services in this office, I assume responsibility for all charges incurred.

We only participate with the following insurance companies:

- Delta Dental
- Delta Dental Healthy Kids
- Delta Dental Healthy Michigan (Dr. Benivegna ONLY)
- BCBS Traditional Dental
- Medicare Medical

Any other insurance claims will be processed as non-participating and it is your responsibility to understand the details of your policy.

*Note: We do not participate with the **medical** portion of Blue Cross Blue Shield. If we are billing your BCBS for a medical procedure, all payments will be paid to the subscriber. It is your responsibility to pay these fees when services are rendered.*

Signature:_____Date:_____

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