PHILIP E. KOCH, D.M.D., P.C. ORAL AND MAXILLOFACIAL SURGERY

CONFIDENTIAL PATIENT INFORMATION
(PLEASE USE INK)

DATE__________AGE____SEX___WEIGHT______DATE OF BIRTH ____-___-____SSN#____-__-_____

PATIENT NAME____ HOME PHONE (   )____-__________
FIRST M.I. LAST
NAME YOU LIKE TO BE CALLED______________________________CELL/PAGER# (   )____-__________

MAILING ADDRESS____
P.O. BOX/STREET ADDRESS CITY STATE ZIP
EMPLOYER____WORK PHONE(   )_____-____________

IF STUDENT – SCHOOL NAME____________________________CITY/STATE______________________
EXPECTED DATE OF GRADUATION___________________

SPOUSE'S NAME_______________________________EMPLOYER_______________________________
WORK PHONE(   )_______-______ SSN#_______-___-_______ DATE OF BIRTH____-____-___
CELL PHONE (   )_______-______
(IF PATIENT IS A MINOR AND/OR STUDENT PLEASE FILL IN INFORMATION BELOW)
FATHER'S NAME_______________________________________EMPLOYER________________________
ADDRESS (if different than patient):____
WORK PHONE (   )_____-______ SSN#_____-_____-______ DATE OF BIRTH___-____-____
CELL PHONE (   )______-______
MOTHER'S NAME_______________________________________EMPLOYER________________________
ADDRESS (if different than patient):____
WORK PHONE (   )____-________SSN#_____-___-______ DATE OF BIRTH____-____-_____
CELL PHONE (   )_____-_________
NEAREST RELATIVE NOT LIVING WITH YOU____________________________RELATIONSHIP___________
ADDRESS____PHONE (   )____-_________

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE)__________________________PHONE(   )____-__________
ADDRESS____
(IF DIFFERENT FROM ABOVE ADDRESS)

INSURANCE INFORMATION – DO YOU HAVE MEDICAL (   ), DENTAL (   ), OTHER:__________
PLEASE GIVE CARD/FORMS TO RECEPTIONIST TO MAKE A COPY. IF RELATED TO AN ACCIDENT PLEASE GIVE DATE OF ACCIDENT_______________ **. DR. KOCH IS NOT A PARTICIPATING PROVIDER WITH MEDICARE UNDER THE DENTIST OPT-OUT AGREEMENT. FOR THIS REASON, NO MEDICARE BENEFITS WILL BE AVAILABLE TO YOU FOR TREATMENT PROVIDED BY DR. KOCH.**

ASSIGNMENT OF BENEFITS
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND ALSO CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I AUTHORIZE PAYMENT OF BENEFITS TO DR. KOCH FOR SERVICES RENDERED.

____
PATIENT OR AUTHORIZED SIGNATURE **DATE**

FINANCIAL AGREEMENT
IF YOU HAVE INSURANCE WHICH WILL COVER YOUR SURGERY, WE WILL FILE IT FOR YOU. YOUR ESTIMATED PORTION WILL BE DUE ON THE DAY SERVICES ARE RENDERED. WE WILL INFORM YOU OF THE ESTIMATED AMOUNT DUE PRIOR TO ANY SURGICAL PROCEDURES. IF YOU DO NOT HAVE INSURANCE OR IF YOUR PROCEDURE IS NOT COVERED UNDER YOUR INSURANCE, PAYMENT IN FULL IS REQUESTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER IF YOU PREFER TO PAY BY THIS METHOD. THERE IS A 5% DISCOUNT FOR PAYMENT IN FULL BY CASH OR CHECK ON THE DAY OF TREATMENT. IF THERE IS ANY BALANCE DUE AFTER INSURANCE PAYMENT YOU WILL BE BILLED AND THE BALANCE WILL BE DUE AT THAT TIME. THERE WILL BE A 1.5% FINANCE CHARGE PER MONTH (18% APR) ON ANY ACCOUNT BALANCES OVER 30 DAYS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE ON UNPAID INSURANCE CLAIMS AND/OR ANY COLLECTION FEES ASSOCIATED WITH THIS ACCOUNT. IF YOU HAVE ANY QUESTIONS ABOUT THIS FINANCIAL AGREEMENT, PLEASE TALK WITH THE RECEPTIONIST AT THE DESK. THANK YOU VERY MUCH.

____
PRINTED NAME OF RESPONSIBLE PARTY

______________________________ ______________
SIGNATURE OF RESPONSIBLE PARTY **DATE** **(PLEASE FILL OUT OTHER SIDE)**

HEALTH HISTORY (PLEASE ANSWER ALL QUESTIONS)

PHYSICIAN________________________ADDRESS________________________
DENTIST________________________ADDRESS________________________
ORTHODONTIST (IF APPLICABLE)________________ADDRESS________________________
NAME OF PERSON REFERRING YOU TO US________________________
HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY BEEN TREATED HERE BEFORE?__________. IF YES
WHO WAS THE PATIENT AND WHAT YEAR WERE THEY TREATED?________________________

REASON FOR THIS VISIT________________________
(If accident related, please describe):________________________

1. DO YOU CONSIDER YOUR GENERAL HEALTH: GOOD___FAIR___OR POOR____
2. ARE YOU NOW, OR HAVE YOU BEEN, UNDER A PHYSICIAN'S CARE DURING THE PAST FIVE YEARS?______
   IF YES, FOR WHAT?________________________
3. DO YOU TAKE ANY MEDICATIONS, DRUGS OR PILLS? IF YES WHAT?________________________
4. ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS, OR PILLS? IF SO, TO WHAT?________________________
5. DO YOU HAVE HAY FEVER OR OTHER ALLERGIES?________________________
6. HAVE YOU EVER HAD ANY SERIOUS ILLNESSES? IF SO, WHAT?________________________
7. HAVE YOU EVER HAD SURGERY OR GENERAL ANESTHESIA (BEEN PUT TO SLEEP)?______. IF SO, FOR WHAT?
8. HAVE YOU EVER BEEN HOSPITALIZED FOR ANYTHING BESIDES SURGERY?_____IF SO FOR WHAT?____________

PLEASE CHECK ALL ANSWERS BELOW YES OR NO	**YES**	**NO**
9. ARE YOU PREGNANT OR TRYING TO GET PREGNANT?		
10. HAVE YOU EVER HAD AN EMOTIONAL OR NERVOUS CONDITION REQUIRING TREATMENT?		
11. HAVE YOU OR ANY FAMILY MEMBER EVER HAD AN UNUSUAL REACTION TO GENERAL ANESTHESIA (BEING PUT TO SLEEP)?		
12. DO YOU NOW HAVE A COUGH OR COLD?		
13. HAVE YOU EVER HAD FACIAL PAIN OR PROBLEMS WITH YOUR JAW JOINTS?		
14. DO YOU WEAR CONTACT LENSES?		
15. DO YOU HAVE AN ARTIFICIAL HEART PACEMAKER?		
16. HAVE YOU EVER HAD SEIZURES, CONVULSIONS, OR EPILEPSY?		
17. DO YOU HAVE A HISTORY OF ALCOHOL AND/OR DRUG ABUSE?		

18. HAVE YOU EVER HAD ANY OF THE FOLLOWING?	**YES**	**NO**
A. HEART DISEASE		
HEART MURMUR		
HIGH BLOOD PRESSURE		
RHEUMATIC FEVER		
HEART ATTACK		
STROKE		
B. LUNG DISEASE		
ASTHMA		
EMPHYSEMA		
BRONCHITIS		
TUBERCULOSIS		
C. KIDNEY DISEASE		
D. LIVER DISEASE		
HEPATITIS (YELLOW JAUNDICE)		
E. DIABETES (SUGAR)		
F. ABNORMAL BLEEDING)		
G. GLAUCOMA		
H. HIV OR AIDS		

____
SIGNATURE OF PATIENT

____
PARENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE OR IS UNABLE TO SIGN HIS OR HER OWN CONSENT)

____
DATE

(PLEASE SEE PAGE THREE)

	YES	NO
19. HAVE YOU EVER TAKEN:		
A. BLOOD THINNERS		
B. CORTISONE (STEROIDS)		
C. DIGITALIS		
D. NITROGLYCERIN		
20. DO YOU HAVE SICKLE ANEMIA OR TRAIT?		
21. DO YOU HAVE AN ARTIFICIAL HIP OR ANY ARTIFICIAL JOINTS?		
22. ARE YOU OF ANY RELIGIOUS BELIEF THAT WILL NOT ALLOW YOU TO RECEIVE A BLOOD TRANSFUSION?		
23. DO YOU WISH TO SPEAK PRIVATELY WITH THE DOCTOR ABOUT ANYTHING?		

	YES	NO
24. HAVE YOU EVER TAKEN MEDICATION FOR OSTEOPOROSIS OR OSTEOPENIA?		

SOME OSTEOPOROSIS MEDICATIONS INCLUDE, BUT ARE NOT LIMITED TO, ACTONEL, FOSAMAX, BONIVA, RECLAST, ZOMETA, AREDIA, DIDRONEL, ATELVIA, SKELID, XGEVA, PROLIA, EVENITY, AVASTIN, AND SUTENT.

PLEASE LIST ANY DRUG YOU HAVE TAKEN FOR OSTEOPOROSIS OR OSTEOPENIA AND HOW LONG YOU HAVE BEEN TAKING IT:

________________________ ________________________

________________________ ________________________

25. HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA?________________________
26. DO YOU HAVE A HISTORY OF SINUS OR NASAL PROBLEMS?________________________
27. DO YOU SMOKE?____________ IF SO, HOW MANY PACKS PER DAY?________________________
28. HAVE YOU HAD ANY CANCER TREATMENT, RADIATION, OR CHEMOTHERAPY?________________________
    DECRIBE:________________________
    DATE OF YOUR LAST TREATMENT:________________________
    HAVE YOU TAKEN OR ARE YOU TAKING ANY CANCER DRUGS?________________________
    PLEASE LIST WHAT YOU HAVE TAKEN OR WHAT YOU ARE TAKING:________________________

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COMMENTS:____

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SIGNATURE OF PATIENT

____
DATE

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PARENT OR LEGAL GUARDIAN (IF PATIENT IS UNDER 18 YEARS OF AGE OR IS UNABLE TO SIGN HIS OR HER OWN CONSENT)