VALLEY ORAL & MAXILLOFACIAL SURGEONS

PATIENT INFORMATION M☐ F☐ Married☐ Single☐ Divorced☐

Name ______________________________ S.S. # ______________
Last First Middle

Address ______________________________ City ______________

State ______________ Zip __________ Telephone # ______________

Age ________ Birthdate ________ Height ________ Weight ________

If full time student, (school) ______________________________

ACCOUNT INFORMATION

Insured Person Relationship ______________

Name ______________________________ S.S.# ______________

Address (if different) ______________________ Birthdate ______________

Occupation ______________________ Employer ______________________

Business Address ______________________ Phone ______________

Insured Person's Spouse

Name ______________________________ S.S.# ______________

Employer ______________________________ Phone ______________

Closest Relative ______________________ Phone ______________

INSURANCE INFORMATION **DENTAL**☐ **MEDICAL**☐ **MEDICARE**☐

Primary

Company ______________________________ S.S.# ______________

Group # ______________ Member # ____________ Union ______________

Secondary

Company ______________________________ S.S.# ______________

Group # ______________ Member # ____________ Union ______________

MISCELLANEOUS INFORMATION

Referred By ____

Patient's Dentist ______________________ Physician ______________

Has any member of your family ever been a patient here?

If so, name of patient ______________________________________

______________________________________ ______________

Signature of Person supplying above information Date

MEDICAL HISTORY

NAME: ______________________________

FAMILY PHYSICIAN: ____________________ PHYSICIAN'S TELEPHONE: ____________________

CIRCLE

1. Are you having pain or discomfort at this time?............................YES NO
2. Do you feel very nervous about having dentistry treatment?..................YES NO
3. Have you ever had a bad experience in the dentistry office?.................YES NO
4. Have you been a patient in the hospital during the past two years?..........YES NO
5. Have you been under the care of a medical doctor during the past two years?..YES NO
6. Are you taking medicine or drugs regularly?.................................YES NO
   PLEASE LIST: ______________________________
7. Are you allergic to (i.e. itching, rash, swelling, of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs of medications?......YES NO
   PLEASE LIST: ______________________________
8. Have you ever had any excessive bleeding requiring special treatment?........YES NO
9. Circle any of the following which you have had or have at present:

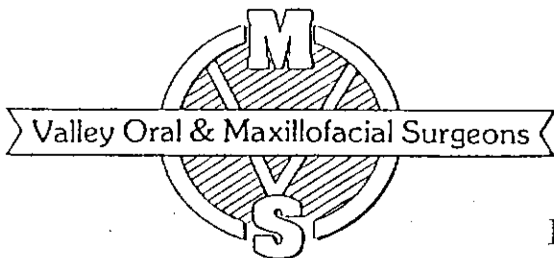
Heart failure	Emphysema	AIDS or HIV
Heart disease or attack	Cough	Hepatitis A (infectious)
Angina pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High blood pressure	Asthma	Liver disease
Heart murmur	Hay fever	Yellow jaundice
Rheumatic fever	Sinus trouble	Blood transfusion
Congenital heart lesions	Allergies or Hives	Drug addiction
Scarlet fever	Diabetes	Hemophilia
Artificial heart valve	Thyroid disease	Venereal disease (Syphilis, Gonorrhea)
Heart pacemaker	X-ray or Colbalt treatment	Cold sores
Heart surgery	Chemotherapy (Cancer, Leukemia)	Genital herpes
Artificial joint	Arthritis	Epilepsy or seizures
Anemia	Rheumatism	Fainting or dizzy spells
Contact Lens	Cortisone medicine	Nervousness
Stroke	Glaucoma	Psychiatric treatment
Kidney trouble	Pain in jaw joints	Sickle cell disease
Ulcers	Bruise easily	

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?.. YES NO
11. Do your ankles swell during the day?.......................................YES NO
12. Do you use more than 2 pillows to sleep?...................................YES NO
13. Have you lost or gained more than 10 pounds in the past year?..............YES NO
14. Do you ever wake up from sleep short of breath?............................YES NO
15. Are you on a special diet?...YES NO
16. Has your medical doctor ever said you have a cancer or tumor?..............YES NO
17. Do you have any disease, condition or problem not listed?..................YES NO
18. WOMEN: Are you pregnant now?...YES NO
    Are you breast feeding?..YES NO
19. HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE LAST 8 HOURS?..................YES NO

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment.

______________________ Date

______________________ SIGNATURE OF PATIENT, PARENT OR GUARDIAN



Jeffrey H. Kootman, D.M.D.

Diplomate
American Board
of Oral and
Maxillofacial Surgery

FINANCIAL POLICY

All accounts are to be paid in full at the time treatment is rendered.

INSURANCE

We will assist you in submitting your insurance claim. However, YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT, NOT THE INSURANCE COMPANY.

If time permits, a pre-treatment estimate can be submitted to your insurance company to determine what portion of your fee the insurance company will pay. With written commitment from the insurance company, we will accept payment from you for the difference between the insurance commitment and the total fee.

If your account is not paid in full at the time of treatment the insurance authorization must be signed so that the check will come to us. If there is an over-payment, we will refund the difference to you via a check at the end of the month.

UNPAID ACCOUNTS

In the event your account is referred to an attorney for collection, you agree to pay my reasonable attorneys fees, collection and court costs incurred in connection there with.

You further agree to pay interest on any unpaid balances at the rate of 18% per annum from the date of service until paid in full.

METHOD OF PAYMENT

Please indicate the manner in which you will handle your account:

1.______ I will pay Cash/Check/Master Charge/Visa/Discover/Amex (circle one)

2.______ I have insurance and wish to submit for pre-authorization.

3.______ I do not have insurance. I understand the full payment is due at the time of service.

Patient's Name ____ Date ____________

Signature of Responsible Party ____

702 East Bell Road, Suite B-103 • Phoenix, Arizona 85022 • (602) 493-1140