



Diplomate of the American Board of Oral & Maxillofacial Surgery
Fellow of the American Association of Oral & Maxillofacial Surgeons

Oral Solutions, NW

Ted Rodich, DDS, P.C.
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Oral Surgery / Dental Implants / Orthognathic Surgery / Oral Pathology

For all patients 18 yrs. and older; please sign all forms enclosed; For Our patients younger than 18 yrs, a Legal Guardian or Parent must sign all forms. Thank you

My staff and I would like to welcome you to our practice. Our entire health care team is committed to working closely with your referring dentist or physician to ensure that we deliver the best possible patient support care.

In order to more effectively utilize the time we have allotted for you, we ask that you **please complete the enclosed 'WELCOME' form and medical history form prior to your appointment.** We make every effort to honor all time commitments as we appreciate that your time is also very important. Unfortunately, on occasion, circumstances arise that create a delay in our schedule however our entire staff works diligently to insure timely delivery of care. In order to assist us to most effectively utilize our time, if you find you will not be able to keep an appointment, we ask that you notify us at least 48 hours in advance whenever possible.

A parent or legal guardian must accompany patients under the age of 18 for us to deliver any care, including consultation appointments. Most oral surgeries require one hour or less. We kindly ask that escorts/drivers for our sedated patients remain in our office during the procedure.

Please remember to bring the completed forms and any x-rays given to you by your dentist with you to your appointment. We look forward to working with you to make your experience in our office as pleasant as possible. Please do not hesitate to call our office with any questions or concerns you may have.

Sincerely,

Dr. Ted Rodich
Marie- Business Manager
Kelsey, Whitney & JoLene - Front Office
Joan, Karri & Michelle - Surgical Staff

WELCOME

Please complete the following confidential information:

Date: _____

Patient: _____ Name Preference: _____
Last Name First Middle

Residence Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work: _____ Cell: _____

Married _____ Single _____ Divorced _____ Other _____

Date of Birth: _____ Age: _____ Sex: _____

If patient is Age 18 or over & Full Time Student / Name of School: _____

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State _____

How long at present employment: _____

Social Security Number: _____ DL#: _____

Current General Dentist: _____ How Long: _____

Emergency Contact: _____ Phone: _____

Referred By: _____

PARENT/LEGAL GUARDIAN ACCOMPANYING A MINOR CHILD-ACCOUNT HOLDER

Name: _____ Social Security Number: _____

Date of Birth: _____

Employer: _____ Occupation: _____

Address: _____ City: _____

Work Phone: _____ Home Phone: _____

Billing Address: _____ City: _____ State: _____

Relationship to Patient: Father _____ Mother _____ Grandparent _____ Other _____

FINANCIAL POLICY

We welcome and encourage frank discussion of services and our fees prior to treatment in order to avoid misunderstandings. **Our financial policy requires payment or estimated copayment in full at time of service.** We accept Cash, Visa, and Mastercard as methods of payment. Checks over \$200 are not accepted without prior approval.

BILLING: There is a \$25 charge to accounts for all bank returned checks that have nonsufficient funds. Please be advised there will be a \$5.00 REBILL fee and interest charges of 1.50% applied to any accounts on delayed payments. Accounts overdue will be subject to collection procedures. Any account sent for collections will assess an additional \$100 processing fee. **If the account should become delinquent, patient agrees to pay for all rebilling charges, interest charged, collection costs and attorney fees.** We consider financial matters important and ask you bring any concerns to our attention.

Signature of **PATIENT** financially responsible for account

Date

Signature of **PARENT** accompanying minor child-Account Holder

Date

INSURANCE: We will do our best to verify any insurance coverage you may be eligible for however the financial obligations for the treatment we render to you are your responsibility. For many of you, your insurance is a contract between you and your employer and we are not a party of that contract. For some of you, we are a contract provider with your insurance company and that contract states that we will agree to lower our fees for service from our regular set fees for those patients with those insurance company benefits however does not remove you from your primary obligation. We are happy to assist you in submitting claims to your carriers for consideration. After our office has received payment from your carrier(s) and any/all applicable adjustments have been made, **your remaining balance** will be billed to you and **is then due and payable upon receipt.** You may also have a credit balance after all insurance payments are posted. All credit balances are issued around the 5th and 25th of each month.

I authorize release of any information relating to this claim. I hereby authorize payment of any insurance benefits due me to: TED RODICH, D.D.S., PC. A copy of this authorization is valid.

Primary Insured Employee

Date

Secondary Insured Employee

Date

PATIENT INFORMATION: Please understand your patient information is held in confidences and that no information will be given out without your signed consent. By signing *this* form it gives us permission to use your information solely for the purpose of collection of your claims.

Name: _____

1. Your personal M.D. _____ Phone _____

2. Has there been any change in your general health in the last two years? Yes No

3. Approximate date of last physical exam _____

4. Are you now under the care of a physician? Yes No

5. Have you had any serious illness, operation or hospitalization within the last five years? Yes No

Please describe _____

6. Are you taking any of the following:

Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cortisone / steroids (within last 2 years)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticoagulants (Blood thinners)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Control Pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Pressure Medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tranquilizers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insulin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Drugs, Nitroglycerin	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List all medications: _____

7. Are you allergic to or had a bad reaction to:

Local Anesthetics (Novocaine, Lidocaine) Yes No

Penicillin or other antibiotics Yes No

Barbiturates, Sedative or Sleeping Medicines Yes No

Aspirin or Codeine Yes No

Any other foods or Medications? Yes No

HAVE YOU HAD ANY OF THE FOLLOWING?

Chronic sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma, emphysema, bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic fever or heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart attack/open heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina/congestive heart failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial joint surgery/implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures, epilepsy, fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes or high blood sugar	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis, jaundice, liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis or joint pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear contact lenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent severe headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness in any part of your face/mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you smoke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, how much	_____	

Current or prior use of prescription medication for weight reduction Yes No

Use of recreation/illicit/illegal drugs Yes No

Excessive use of alcohol/alcoholism Yes No

Drug addiction therapy Yes No

Psychiatric problems Yes No

Developmental Disability Yes No

Current Contagious Diseases Yes No

Tuberculosis Yes No

Venereal Diseases Yes No

AIDS/HIV Yes No

Abnormal bleeding after surgery Yes No

Hemophilia, anemia, sickle cell Yes No

Radiation treatment for tumor/cancer Yes No

Thyroid disease or goiter Yes No

Problems with opening mouth wide or TMJ Yes No

Injury to face, jaws, or neck Yes No

Problems with anesthesia Yes No

Problems with surgery Yes No

Problems with past dental treatment Yes No

If yes, what _____

Females, are you pregnant? Yes No How many months? _____

If there are any other medical problems or conditions you think I should be aware of, please describe _____

If you are completing this form for another person, what is your relationship to that person? _____

Your name _____

I HAVE READ AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THIS OFFICE OF ANY FUTURE CHANGES IN THE HEALTH OR MEDICATIONS TAKEN BY THIS PATIENT.

Signature of Patient _____ Date _____

Signature of parent or guardian (if patient is a minor) _____ Date _____

Signature of Doctor _____ Date _____

Signature of Assistant _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

(To be retained by Ted Rodich, DDS PC)

I understand that Ted Rodich DDS, PC will use and disclose health information about me in the course of providing any oral surgery I may need while in his care.

I understand that my health information may include information both created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand that the office of Ted Rodich, DDS PC is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult and coordinate with my referring dentist and other health care providers in the course of my treatment
- Determine my eligibility for insurance coverage, submit bills, claims and other related information to insurance companies or others who may assist in paying for some or all of my health care
- Perform various office, administrative and business functions that support the office's ability to provide me with appropriate care

I also understand that I have the right to receive a written Notice of Privacy Practices which describes how the office uses and discloses health information, the information practices followed by the office staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised notice upon request. I also understand that Notice of Privacy Practice in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the office is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices. I fully understand I am of no obligation to sign this form.

PRINT NAME

SIGNATURE

DATE

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

Individual refused to sign Communication barriers An emergency or other

