Ted Rodich, DDS, P.C.
Oral & Maxillofacial Surgery
22400 Salamo Rd. Suite: 205
West Linn, Oregon 97068
503-657-8787 FAX: 503-657-5522
Oral Surgery / Dental Implants / Orthognathic Surgery / Oral Pathology

Patient______________________________ **Scheduled Appt** ____________________

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 for 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. Rodich — Marie- Business Manager

Amie & Kelsey- front office — Shannon, Joan & Michelle - surgical staff

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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______

OVER PLEASE

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	❑ Yes	❑No	Cortisone / steroids (within last 2 years)	❑ Yes	❑ No
Anticoagulants (Blood thinners)	❑ Yes	❑No	Birth Control Pills	❑ Yes	❑ No
Blood Pressure Medication	❑ Yes	❑No	Tranquilizers	❑ Yes	❑ No
Insulin	❑ Yes	❑No	Heart Drugs, Nitroglycerin	❑ Yes	❑ 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	❑ Yes	❑No	Current or prior use of prescription medication for weight reduction	❑ Yes	❑ No
Asthma, emphysema, bronchitis	❑ Yes	❑No	Use of recreation/illicit/illegal drugs	❑ Yes	❑ No
Rheumatic fever or heart disease	❑ Yes	❑No	Excessive use of alcohol/alcoholism	❑ Yes	❑ No
Congenital heart disease	❑ Yes	❑No	Drug addiction therapy	❑ Yes	❑ No
Heart attack/open heart surgery	❑ Yes	❑No	Psychiatric problems	❑ Yes	❑ No
Angina/congestive heart failure	❑ Yes	❑No	Developmental Disability	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑No	Current Contagious Diseases	❑ Yes	❑ No
High blood pressure	❑ Yes	❑No	Tuberculosis	❑ Yes	❑ No
Stroke	❑ Yes	❑No	Venereal Diseases	❑ Yes	❑ No
Artificial joint surgery/implants	❑ Yes	❑No	AIDS/HIV	❑ Yes	❑ No
Seizures, epilepsy, fainting	❑ Yes	❑No	Abnormal bleeding after surgery	❑ Yes	❑ No
Diabetes or high blood sugar	❑ Yes	❑No	Hemophilia, anemia, sickle cell	❑ Yes	❑ No
Hepatitis, jaundice, liver disease	❑ Yes	❑No	Radiation treatment for tumor/cancer	❑ Yes	❑ No
Arthritis or joint pain	❑ Yes	❑No	Thyroid disease or goiter	❑ Yes	❑ No
Do you wear contact lenses	❑ Yes	❑No	Problems with opening mouth wide or TMJ	❑ Yes	❑ No
Stomach ulcers	❑ Yes	❑No	Injury to face, jaws, or neck	❑ Yes	❑ No
Frequent severe headaches	❑ Yes	❑No	Problems with anesthesia	❑ Yes	❑ No
Numbness in any part of your face/mouth	❑ Yes	❑No	Problems with surgery	❑ Yes	❑ No
Do you smoke	❑ Yes	❑No	Problems with past dental treatment	❑ Yes	❑ No
If yes, how much ____________			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 ____________

MEDICAL HISTORY

Date: ____________________

Health Changes: ____________________

CURRENT MEDICATIONS ____________________

1 ____________________

2 ____________________

3 ____________________

4 ____________________

Physician's Name ____________________

Last Physical Exam ____________________

Physician's Phone ____________________

Allergies? ____________________

Patient Signature ____________________ Staff Initials ____________________

Date: ____________________

Health Changes: ____________________

CURRENT MEDICATIONS ____________________

1 ____________________

2 ____________________

3 ____________________

4 ____________________

Physician's Name ____________________

Last Physical Exam ____________________

Physician's Phone ____________________

Allergies? ____________________

Patient Signature ____________________ Staff Initials ____________________

Date: ____________________

Health Changes: ____________________

CURRENT MEDICATIONS ____________________

1 ____________________

2 ____________________

3 ____________________

4 ____________________

Physician's Name ____________________

Last Physical Exam ____________________

Physician's Phone ____________________

Allergies? ____________________

Patient Signature ____________________ Staff Initials ____________________

Date: ____________________

Health Changes: ____________________

CURRENT MEDICATIONS ____________________

1 ____________________

2 ____________________

3 ____________________

4 ____________________

Physician's Name ____________________

Last Physical Exam ____________________

Physician's Phone ____________________

Allergies? ____________________

Patient Signature ____________________ Staff Initials ____________________