Patient History

Your Appointment Today is With Dr. _____

Name _____ **Status: S M W D**

Last First Middle Initial

Address _____

Number a Street City State Zip Code

Home Phone # _____ Business Phone # _____

Age: _____ Birthdate: _____/_____/_____ Sex: M F Soc. Sec. # _____

Employer _____ Position _____

Address _____

Number a Street City State Zip Code

Medical Ins. Co. Name _____ Dental Ins. Co. Name _____

Policy # _____ Policy# _____

Medical Doctor _____ Telephone _____

General Dentist _____ Telephone _____

Orthodontist _____ Telephone _____

Referred By _____ Telephone _____

Insured If Other Than Patient

Check One: __ Spouse __ Mother __ Father __ Guardian	Drivers Lic. #

Name _____ **Status: S M W D**

Last First Middle Initial

Address _____

Number a Street City State Zip Code

Home Phone # _____ Business Phone # _____

Age: _____ Birthdate: _____/_____/_____ Sex: M F Soc. Sec. # _____

Employer _____ Position _____

Address _____

Number a Street City State Zip Code

Medical Ins. Co. Name _____ Dental Ins. Co. Name _____

Policy # _____ Policy# _____

Check One: __ Spouse __ Mother __ Father __ Guardian	Drivers Lic. #

Name _____ **Status: S M W D**

Last First Middle Initial

Address _____

Number a Street City State Zip Code

Home Phone # _____ Business Phone # _____

Age: _____ Birthdate: _____/_____/_____ Sex: M F Soc. Sec. # _____

Employer _____ Position _____

Address _____

Number a Street City State Zip Code

Medical Ins. Co. Name _____ Dental Ins. Co. Name _____

Policy # _____ Policy# _____

OFFICE POLICY

Your health, comfort, and satisfaction are the primary concerns of the doctors and members of their office staff. Please inform us of any condition which may require special attention or consideration, so we can insure that your visits with us are a pleasant experience. The nature of an oral and maxillofacial surgery practice includes the management of untimely emergencies. We attempt to accommodate patients who are in distress without disrupting our scheduled appointments, but, this is not always possible. However, we respect the importance of your time, so when we are unavoidably behind schedule, we will attempt to notify you prior to your arrival in our office, so you may have the option of scheduling your appointment at a slightly later time the same day or on another day convenient for you. In this manner we can insure adequate time for your health care. An estimate of your investment for your health care will be provided during the consultation after your personalized treatment plan is discussed. Our business office encourages payment of professional fees at the time of service and will accept cast, personal check, Visa, or MasterCard for your convenience. Our business office staff will gladly assist you in the preparation of your insurance claim forms, so you may be reimbursed the maximum amount allowed by your particular plan. Please note that some insurance companies reimburse claims on the basis of an average table of allowances rather than a specific percentage of the actual professional fee. If your reimbursement from your insurance company is less that we estimate, because the company utilizes an average table of allowances, we will not be surprised, since we do not provide merely average health care. We participate with Delta Dental Plan, accept assignments of benefits from certain insurance companies, and encourage the payment of the patient's portion at the time services are provided. Arrangements for a payment plan may be made without business office under certain circumstances at the consultation appointment. Statements for outstanding accounts are mailed at the end of each month and payments are appreciated within 10 days. If you fail to make a payment or contact our business office regarding an account which has been delinquent for more than 45 days, our auditor will automatically assign the account to a collection agency.

ACCEPTANCE

I recognize and accept PERSONAL RESPONSIBILITY for the payment of professional fees, regardless of any dental or medical plan I have which may apply. I authorize the oral surgeons in this practice and members of their staff to complete an appropriate examination, to obtain necessary radiographs (x-rays), dental casts, and photographs for proper documentation and diagnosis of my problem. I also authorize these doctors to release information regarding my examination and/or treatment to insurance companies or professionals concerned with my health. I will immediately inform the doctors in this practice in the event I feel any problem of any sort has arisen in connection with my dental or medical care, so they may have the opportunity to help me resolve it. I am aware that some professional services require the assistance of outside laboratories. Fees for providers of these services are NOT included in your surgical fee, and are the responsibility of the patient. You will be billed directly by the laboratory. If you have any questions, please inquire out billing office.

Patient or guardian of minor	Date	Witness

ASSIGNMENT OF BENEFITS

I hereby authorize payments directly to R.M. Kaminishi, D.D.S., Inc. Insurance benefits otherwise payable to me.

Signed (insured person)	Date