Office (701) 478-4404
Fax (701) 478-4407
Toll Free Phone (866) 478-4404

PRAIRIE
Oral Surgery
Edward F. May D.D.S.

Patient Information Profile

Patient's Name: _____ Today's Date: ____/____/____
Last First MI

Date of Birth: _____/_____/_____Age:_____ Social Security No:_____
Marital Status: Single Married Divorced Widowed (circle one) Male / Female (circle one)
Address: _____
City:_____State:_____ Zip Code:_____
Primary Phone: _____-_____-_____ Home Cell (circle one)
Secondary Phone: (if applicable) _____-_____-_____ Home Cell Work (circle one)
Patient Employer: _____Employer Phone:_____-_____-_____
Referring Dentist:_____

If the patient is a minor, please provide the following information:

Mother's Name: _____ Mother's Phone: ____-_____-_____ Home Cell (circle)
Father's Name: _____ Father's Phone: _____-_____-_____ Home Cell (circle)
Lives with: Mother Father Both (Circle one) Other, please explain:_____

Responsible Party: (if different from patient or if patient is a minor)

Name: _____Relationship to patient: _____
Address: _____City:_____ State:_____ Zip:_____
Social Security Number: _____ Phone:_____-_____-_____

Emergency Contact:

Name:_____ Relationship to Patient:_____

Phone Number(s): _____

Insurance Information:

PRIMARY DENTAL INSURANCE:

Name of Insurance Co:_____ Claims Phone Number:_____

Insurance Address:_____ City:_____ State: _____ Zip:_____

Policy Holder's Name: _____ Date of Birth: _____-_____-_____

Policy Holder's Employer: _____Plan ID or SS#:_____

SECONDARY DENTAL INSURANCE:

Name of Insurance Co:_____ Claims Phone Number:_____

Insurance Address:_____ City:_____ State: _____ Zip:_____

Policy Holder's Name: _____ Date of Birth: _____-_____-_____

Policy Holder's Employer: _____Plan ID or SS#:_____

PRIMARY MEDICAL INSURANCE:

Name of Insurance Co:_____ Claims Phone Number:_____

Insurance Address:_____ City:_____ State: _____ Zip:_____

Policy Holder's Name: _____ Date of Birth: _____-_____-_____

Policy Holder's Employer: _____Plan ID or SS#:_____

SECONDARY MEDICAL INSURANCE:

Name of Insurance Co:_____ Claims Phone Number:_____

Insurance Address:_____ City:_____ State: _____ Zip:_____

Policy Holder's Name: _____ Date of Birth: _____-_____-_____

Policy Holder's Employer: _____Plan ID or SS#:_____

If Accident Related ONLY:

Name of Insurance Co:_____ Claims Phone Number:_____

Insurance Address:_____ City:_____ State: _____ Zip:_____

Policy Holder's Name: _____ Date of Birth: _____-_____-_____

Date of Injury:_____ Description: _____Plan ID or SS#:_____

Release of Information for Routine Care & Notice of Privacy Practices

The following release will allow us to share pertinent information regarding your care to enhance your treatment and /or financial reimbursement for services received:

1. I authorize Prairie Oral Surgery to share information regarding my course of treatment and the services received with my referring medical and dental providers in order to enhance my continuing treatment and care.

2. I authorize Prairie Oral Surgery and /or any other medical provider or supplier of services in this office to release any information required to secure payment for services received or the payment of the benefits on my behalf. I authorize the use of this signature on all insurance submissions.

3. I have had the opportunity to review this office's Notice of Privacy Practices.

Signed: _____Patient/or Guardian if minor Date:_____

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Patient Medical History

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Primary Medical Doctor: _____Clinic Name/Location: _____

***Past and Present* Medical History: Please check (X) the box next to any illness or problem that applies you.**

□ AIDS/ HIV Positive	□ Chemotherapy	□ Mitral Heart Valve Disease	□ Psychiatric Care
□ Alzheimer's/Dementia	□ Congenital Heart Disorder	□ Heart Pace Maker	□ Radiation Treatments
□ Anaphylaxis	□ Congestive Heart Failure	□ Heart Trouble/Disease	□ Renal Dialysis
□ Anemia	□ Cortisone/Steroid Treatment	□ Hepatitis A, B, C	□ Rheumatic Fever
□ Angina or Chest Pain	□ High Cholesterol	□ Hiatal Hernia	□ Sinus Trouble
□ Anxiety	□ Depression	□ High Blood Pressure	□ Stomach/Intestinal Disorder
□ Arthritis/ Gout	□ Diabetes	□ Hypoglycemia	□ Stroke
□ Artificial Heart Valve	□ COPD/Emphysema	□ Irregular Heartbeat	□ Swelling of Limbs
□ Artificial Joint	□ Epilepsy/Seizures	□ Kidney Disease	□ Thyroid Disease
□ Asthma	□ Fainting/ Dizziness	□ Leukemia	□ Tuberculosis
□ Blood Disease	□ Heartburn/ GERD (reflux)	□ Liver Disease	□ Ulcers
□ Bleeding Disorder	□ Glaucoma/ Eye Disease	□ Low Blood Pressure	□ Yellow Jaundice
□ Birth Defect	□ Heart Attack	□ Lung Disease	□ Other: _____
□ Cancer	□ Heart Murmer	□ Pain in Jaw Joints	

History of Surgeries/ Procedures:

Reason for Hospitalization or Outpatient Surgery	***Date:***

YES or NO Are you taking medications to treat a medical condition?

List **Current** Medical Conditions you are being treated for:_____

_____

YES or NO Do you use tobacco products? if yes, how much per day/ type?_____

YES or NO Are you required by a physician to take antibiotics prior to dental appointments? _____

YES or NO Do you take a medication that is a blood thinner? Please list: _____ _____

YES or NO Do you or a family member have problems with anesthesia including malignant hyperthermia (MH)?

WOMEN: Are you Pregnant? **YES or NO** | Are you nursing? **YES or NO** | Taking Oral Contraceptives? **YES or NO**

Please list all current medications, including over the counter medications or supplements:

Please list ALL ALLERGIES to medications, Latex, metals, products, foods or the environment:

" I understand the importance of providing a truthful medical history to assist my doctor in providing the best care possible. I certify that the information provided here is accurate and complete and that I will ask questions of my doctor and assisting staff to clarify any items I do not understand. "

Patient/Guardian Signature: _____ Today's Date:_____

Financial Policy – Prairie Oral Surgery

Thank you for choosing Prairie Oral Surgery

Thank you for choosing Prairie Oral Surgery as your health care provider. We are grateful that you are entrusting your care to us. Please understand that payment of your bill is considered part of your treatment experience. The following is a statement of our Financial Policy. We require that you read and sign your agreement.

You Are Responsible for Your Bill

As the recipient of our services, you are responsible for the charges associated with each of the services you received during the course of your treatment. You (or your guardian, if you are a minor), must pay for the services you receive from our office. Many patients have insurance, financial support from family members, who may pay all or a portion of your bill on your behalf, but you remain legally responsible for your bill.

Payment for Our Services is Due on the Day You Receive Services

Payment for our services is due on the day you receive the services. If you have no insurance, the entire amount of your bill will be due on the day of your appointment. If this amount is difficult for you to pay out of pocket on the day of your appointment, we have several financing plans available to you outside of our practice. We are unable to finance your treatment through our office. You cannot pay your bill "over time" or "on account" through our office. We would be happy to help you obtain financing for our services before treatment is rendered through several financing companies we work with.

If You Have Insurance

If you have dental or medical insurance, we will assist you in receiving the maximum allowable benefits available under your insurance policies. We will file a claim for services on your behalf, and in many cases we can receive some payment directly from your insurance company. By signing this form, you authorize payment directly to Prairie Oral Surgery for all insurance benefits otherwise payable to you for services rendered to you or on behalf of your dependants. However, you remain responsible for your bill, not your insurance company. **If, after 60 days, we are unable to receive payment for services on your behalf after following normal claim submission procedures, we will expect payment in full from you.**

We Will Collect the Estimated Amount You Will Owe at Your Appointment

Depending on your insurance, we will collect on the day of your appointment the amount estimated to be your responsibility. We determine this amount by estimating the services and charges we think you may receive and then subtract the amount we believe your insurance company may pay on your behalf (based on the insurance information you give us). We then ask you pay the remainder on the day you receive services. You may require additional services (or fewer services), in which case your charges may be greater or less than our estimate. Please keep in mind that this is only an estimate and we cannot pre-determine the exact services you will require or guarantee the final payment amount from your insurance companies.

Questions? Please Ask Our Staff

Our staff is trained to answer your questions regarding your bill and payment arrangements. We do our best to stay on top of insurance plans and would be happy to help you try to understand all of the confusing details and provisions found in many insurance plans. We don't mind talking about money and bills, so please, feel comfortable discussing our charges and your bill.

"I have read and understand this Financial Policy, agree to its provisions, and accept responsibility for this account."

Signed _____ **Date** _____

Patient *(or Parent/Guardian, if minor)*

Signatory's Social Security Number _____

Prairie Oral Surgery

I have received a copy of the Notice of Privacy Practices of Prairie Oral Surgery. I hereby authorize, as indicated by my signature below, to use and disclose my Protected Health Information (PHI) for any necessary treatment, payment or office procedures.

_____

Signature of Patient or Guardian (if minor) Date

_____

Print Name Relationship to patient if minor

Please check your preferred means of communication (you may check more than one)

- □ You may contact me at my home telephone number:_____
- □ You may contact me on my mobile telephone number:_____
- □ You may contact me on my work telephone number:_____
- □ You may send me an email at:_____
- □ Other:_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) ***in addition to*** custodial parents and legal guardians:

1. _____Phone:_____ Date added/removed: _____

2. _____ Phone: _____ Date added/removed:_____

3. _____ Phone: _____ Date added/removed:_____

FOR OFFICE USE ONLY

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 prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining the acknowledgement
- □ Other (Please specify)_____

Staff Personnel Initials:_____ Date:_____