*MICHIANA
ORAL AND
MAXILLOFACIAL
SURGERY, LLC
707 N. MICHIGAN STREET
MEMORIAL MEDICAL PLAZA
SUITE 300
SOUTH BEND, IN 46601
PH. (574) 289-0080*
info@michianaomfs.com

BERNARD J. ASDELL, D.D.S.

Patient Name ______________________________ *DOB* ________________________

I understand that fees are due when services are rendered. **If other arrangements are necessary, they need to be made before service is rendered.** I understand that, as a courtesy, insurance will be filed, but the RESPONSIBLE PARTY is financially responsible for all charges. Any amount failed to be paid by the insurance company is between the RESPONSIBLE PARTY and the insurance company. Accounts are to be paid in full within 60 days from the date of service, and may be subject to a "LATE CHARGE" of $5 per month in the event the account is not paid in full during this period. I understand that in the event of collection activity, the RESPONSIBLE PARTY will be held liable for all interest charges, collection fees, reasonable attorney's fees, and court costs. I understand that credit inquiries are done on a routine basis.

The Patient, by the signature below, or if a minor, by the parent or responsible party, authorizes payment directly to Dr. Asdell of the group insurance benefits otherwise payable to Patient. The signature also authorizes the release of any dental/medical information necessary to process any claims and authorizes that this document serve as valid signature on file should it become necessary in the processing of additional claims.

I authorize Michiana OMFS to speak to the person (s) listed below about any information, regarding treatment, insurance and charges incurred in this office.

____

(Relationship to patient)

____

(Relationship to patient)

PATIENT'S SIGNATURE (Parent or Guardian, if minor)______________________________ Date __________________

RESPONSIBLE PARTY (If different than patient)_______________________________ Date __________________

PATIENT INFORMATION

NAME ______________________________ Name Preferred__________ Sex: M ❑ F ❑
First Middle Init Last
Home Phone ( ) __________ Work Phone ( ) __________ ext _____ Social Security#__________
Cell Phone ( ) __________ Email Address __________
Address__________ City__________ State________ Zip__________
Birth date__________ Age__________ Marital Status: Single❑ Married❑ Divorced❑ Separated❑ Widowed❑
Employer__________ Occupation__________ # Years Employed________ Full-Time❑ Part-Time❑
Employer's Address__________ City__________ State________ Zip__________
Who is your Dentist? __________ Orthodontist? __________ Physician? __________Phone # __________
Who may we thank for referring you to our office? __________
Have you or any other family member ever been seen in this office? ________ If yes, whom & when? __________
Emergency contact person, **OUTSIDE OF IMMEDIATE HOUSEHOLD**? __________ Phone ( ) __________
If patient is a student, please complete:
Name of School__________ City__________ State________ Full-Time❑ Part-Time ❑

RESPONSIBLE PARTY INFORMATION

NAME______________________________ Sex: M ❑ F ❑
First Middle Init Last
Home Phone ( ) __________ Work Phone ( ) __________ ext ________
Cell Phone ( ) __________ Email Address __________
Address__________ City__________ State________ Zip__________
How long at this address? __________ Marital Status: Single❑ Married❑ Divorced❑ Separated❑ Widowed❑
Previous address (if less than 3 years) __________ City__________ State________ Zip__________
Birthdate__________ Social Security #__________ Relationship to Patient__________
Employer__________ Occupation__________ # Years Employed________ Full-Time❑ Part-Time❑
Employer's Address__________ City__________ State________ Zip__________
SPOUSE__________ Work Phone ( ) __________ ext________
Birthdate__________ Social Security #__________ Relationship to Patient__________
Employer__________ Occupation__________ # Years Employed________ Full-Time❑ Part-Time❑
Employer's Address__________ City__________ State________ Zip__________

INSURANCE INFORMATION

PRIMARY Insurance Company Name__________ Phone ( ) __________
Insurance Company Address__________ City__________ State________ Zip__________
ID #__________ Group #__________ Medical❑ Dental❑ Both❑
Policy Holder's Name__________ Birthdate__________ Relationship to Patient__________
Address__________ City__________ State________ Zip__________
Is insurance through employer? ________ If yes, list employer__________
SECONDARY Insurance Company Name__________ Phone ( ) __________
Insurance Company Address__________ City__________ State________ Zip__________
ID #__________ Group #__________ Medical❑ Dental❑ Both❑
Policy Holder's Name__________ Birth date__________ Relationship to Patient__________
Address__________ City__________ State________ Zip__________
Is insurance through employer? ________ If yes, list employer__________

PATIENT'S MEDICAL HISTORY

Height _________ Weight ___________ BMI____________________
(STAFF USE ONLY)

Yes	No	
____	____	Are you allergic to any foods or medications, adhesives or latex products? ________________________
____	____	Are you taking **ANY MEDICATIONS?** List____
		____
____	____	Are you taking any herbal supplements? List____
____	____	Are you taking, **or have you ever taken** bone-enhancing drugs, ie Fosomax, Actonel, Reclast, etc? List ____________
____	____	Are you now under the care of a physician? What condition is being treated? ____________________
____	____	Are you taking aspirin or blood thinning agents? How often? ____________________________
____	____	Have you had any serious illnesses or operations within the last 5 years? Describe____________________
____	____	Do you smoke? How much? ____
____	____	Have you ever had a problem with drug/substance abuse (includes alcohol)? Describe ________________
____	____	Are you pregnant? Estimated delivery date? ______________________________________
____	____	Are you breastfeeding? Taking Birth Control Pills? ______Yes ______No
____	____	**Do you have any disease, condition or problem not listed that you think we should know about?**
		Describe ____

PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS.

Yes	No		Yes	No	
____	____	Anemia	____	____	Hyperactive
____	____	Asthma	____	____	Hypoglycemia
____	____	Bleeding problems of any kind	____	____	Joint Replacement
____	____	Cancer	____	____	Pneumonia
____	____	Convulsions/Epilepsy	____	____	Stomach Ulcers
____	____	Diabetes	____	____	Stroke
____	____	Faint or tire easily	____	____	Surgery or X-ray for tumor
____	____	Heart Valve Replacement	____	____	Tuberculosis (TB)
____	____	Heart problems of any kind	____	____	Unusual weight loss
____	____	Hepatitis	____	____	Venereal disease
____	____	High blood pressure	____	____	TMJ Problems (jaw joint problems)
____	____	HIV+/AIDS			

I understand that the information I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical and residential status.
The Patient, by the signature below, or if a minor, by the parent or responsible party, agrees that permission is granted for treatment by Dr. Asdell.

I understand that fees are due when services are rendered. If other arrangements are necessary, they will need to be made before service is rendered. I understand as a courtesy, insurance will be filed, but the RESPONSIBLE PARTY is financially responsible for all charges. Any amount not paid by the insurance company is between the RESPONSIBLE PARTY and the insurance company. Accounts are to be paid in full within 60 days from the date of service, and may be subject to a "LATE CHARGE" OF $5 per month in the event the account is not paid in full during this period. I understand that in the event of collection activity, the RESPONSIBLE PARTY will be held liable for all interest charges, collection fees, and reasonable attorney's fees, and court costs.

PATIENT'S SIGNATURE (Parent or Guardian, if minor) ______________________________ Date ________________________

RESPONSIBLE PARTY (If different than patient) __________________________________ Date ________________________

UPDATED SIGNATURE ____Date ________________________