ecioms
East Central Indiana Oral & Maxillofacial Surgery

Chris D. Kinney, D.D.S.
Harry Papadopoulos, D.D.S., M.D.
Trevor Treasure, D.D.S., M.D.

PATIENT REGISTRATION INFORMATION (please print) **Date:** _____

Name: _____ Gender ( ) M ( ) F Birth Date: ____ - ____ - ____
Preferred Name: _____ Age: _____ Weight: _____

SS# _____ - _____ - _____ Marital Status: ( ) Married ( ) Divorced ( ) Single
( ) Separated ( ) Widowed ( ) Partner
Address: _____ Employer: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Home Phone: _____ Cell Phone: _____
Full Time Student? ( ) Yes ( ) No
Physician: _____ Phone: _____
Dentist: _____ Phone: _____
Nearest Relative Not living with you: _____ Phone: _____

Person who Carries 1st Insurance

Name: _____
SS#: _____ - _____ - _____
Birth Date: _____ Gender ( ) M ( ) F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
Employer: _____
Work Phone: _____
Marital Status: ( ) Married ( ) Divorced
( ) Single ( ) Separated ( ) Widowed ( ) Partner

Person who Carries 2nd Insurance

Name: _____
SS#: _____ - _____ - _____
Birth Date: _____ Gender ( ) M ( ) F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____
Employer: _____
Work Phone: _____
Marital Status: ( ) Married ( ) Divorced
( ) Single ( ) Separated ( ) Widowed ( ) Partner

1st Dental Insurance Name: _____ 1st Medical Insurance Name: _____
2nd Dental Insurance Name: _____ 2nd Medical Insurance Name: _____

I authorize ECIOMS to release any information necessary to file a claim with my insurance company. I authorize my insurance company to pay benefits directly to ECIOMS for services provided either for me or a covered dependent.
I understand that I am financially responsible for treatment performed by ECIOMS regardless of any insurance coverage or other circumstances. If my account is turned over to collections, I understand that additional collection fees and legal fees will be added to the account.

X _____ _____
Signature of patient (if over 18 years old) or person responsible for payment Date:

CORE MEDICAL HISTORY

1. Are you now or have been under the care of a physician during the last 2 years? ..... YES NO

   If yes, for what reason _____

2. Are you taking any medicine or drugs at the present time? ..... YES NO

   If yes, please list _____

   _____

3. Are you allergic to any medicine or drugs? ..... YES NO

   If yes, please list _____

   _____

4. Do you have a cold, sore throat, or upper respiratory illness now? ..... YES NO
5. Do you get short of breath or have chest pain? ..... YES NO
6. Have you ever had excessive bleeding from wounds or extractions? ..... YES NO
7. Have you ever taken cortisone or steroids? ..... YES NO
8. Have you been treated for osteoporosis? ..... YES NO
9. Do you use non prescribed drugs or have been treated for drug abuse? ..... YES NO
10. Do you smoke or use tobacco products? ..... YES NO
11. Have you had a general anesthetic in the past? ..... YES NO
12. What is your oral surgical problem? _____
13. Mark yes or no to any past or present conditions:

	YES	NO		YES	NO		YES	NO
Asthma	☐	☐	Anemia	☐	☐	Radiation Treatment	☐	☐
Tuberculosis	☐	☐	Stomach Problem	☐	☐	High Blood Pressure	☐	☐
Lung Disease	☐	☐	Thyroid Disease	☐	☐	Diabetes	☐	☐
Stroke	☐	☐	Syphilis or Venereal Disease	☐	☐	Psychiatric Disorder	☐	☐
Heart Disease	☐	☐	Seizures (Epilepsy)	☐	☐	Hepatitis (Yellow Jaundice)	☐	☐
Heart Murmur	☐	☐	Cancer	☐	☐	Implant of any kind	☐	☐
Rheumatic Fever	☐	☐	AIDS / H.I.V.	☐	☐	Glaucoma	☐	☐
Pacemaker	☐	☐	Fainting Spells	☐	☐	TMJ Pain	☐	☐
Kidney Disease	☐	☐	Sinus Problems	☐	☐			

14. List any health problem not covered above _____
15. Have you been hospitalized in the past 5 years? ..... YES NO

    If yes, for what reason? _____
16. (Women) Are you pregnant? YES NO If so, how many months? _____ Dr. _____
17. If this office visit is a result of an accident, please give details _____

    _____

    _____

Signature: _____ Date: _____

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Muncie Office
3700 N. Briarwood Ln., Ste. D
Muncie, IN 47304
(765) 281-1131

New Castle Office
1520 Washington St.
New Castle, IN 47362
(765) 521-0390

Greensburg Office
1463 W. Westridge Pkwy., Ste. B
Greensburg, IN 47240
(812) 527-0973

Authorization to Release Health Care information

Patient's name: _____Date of birth: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me (to the recipients listed below) as described below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I know that East Central Indiana Oral & Maxillofacial Surgery will have no control over the information re-disclosed by the recipient.

Note: Recipients are required to show proof of their identity prior to the release of any information.

Recipient(s):

Name: _____ Relationship _____ Address _____

Name: _____ Relationship _____ Address _____

OR: NONE: _____ (Do not release information to anyone)

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment: _____

THIS AUTHORIZATION IS TO EXPIRE ON: _____.

I may cancel this authorization at any time by notifying East Central Indiana Oral & Maxillofacial Surgery in writing. If I choose to do so, my revocation will not affect any actions taken by East Central Indiana Oral & Maxillofacial Surgery before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
THIS CONSENT IS TO BE INCLUDED IN THE PATIENT'S CHART AFTER IT HAS BEEN COMPLETED.

PLEASE COMPLETE REVERSE SIDE

For office use only: Copy of signed authorization provided to the individual
Date: _____Initials: _____.

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ACKNOWLEDGEMENT OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This acknowledgment

I, _____have been informed of the availability of this oftice's **Notice of Privacy Practices**, I understand that free copies are available in the reception area and that a copy is posted in the reception area should I wish to read it there.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

Staff Signature _____

PLEASE COMPLETE REVERSE SIDE