



NORTHEAST  
*Oral &  
Maxillofacial  
Surgery*

Brent T. Garrison, DDS, MSD

Corbin G. Partridge, DMD

Patrick S. Kelly, DDS\*

Diplomates of the American Board of Oral and Maxillofacial Surgery  
\*Board Eligible

Welcome to Northeast Oral & Maxillofacial Surgery! We appreciate the opportunity to be of service to you. Please complete the enclosed **Patient Information** and **Medical History forms** in black or blue ink only. You will need to bring the completed forms along with your current **Insurance card and photo ID** to your next scheduled appointment. Note: the **Patient Information form** may also be completed on-line 48 hours prior to your appointment but it is recommended that you print out a copy and bring it with you, as well.

You are encouraged to schedule a **preoperative consultation** to discuss your planned procedure. We will also discuss your health history and/or medications you may be taking, especially if you have experienced any of the following conditions:

Serious health problems	Artificial heart valve	Dialysis
Diabetes	Artificial hip or knee joint	Latex allergy
Heart murmur	Take blood thinners	Bleeding disorders
Recent use of diet pills		

You will also discuss with the doctor several anesthesia options for your comfort:

**Local anesthesia** - Numbing injections are given in the appropriate area(s). It is not necessary to change your eating habits before your appointment. Please take any prescription medications as you normally would. If you are pregnant, then local anesthesia is recommended.

**Nitrous oxide and local anesthesia** - Nitrous oxide gas is administered to produce a relaxed, awake state. Numbing injections are then given. It is not necessary to change your eating habits before your appointment unless you are instructed otherwise.

**Intravenous anesthesia** - Intravenous (IV) medications are given to produce a semiconscious or unconscious condition. The numbing injections and surgery are accomplished while you sleep. Following the surgery, you should plan to rest at home for the remainder of the day.

Please note the following if you prefer IV anesthesia:

- ◆ You must not eat or drink for at least six hours before your appointment. You may take prescription medications with a small amount of water.
- ◆ You will need to have a responsible adult with you to drive you home. **This is very important!** Your escort must be present before and during your procedure, and should plan to stay with you the remainder of that day.

*(Please continue on back)*

- ◆ You should wear comfortable, loose-fitting clothing. Short sleeves are desirable.
- ◆ Remove all jewelry before your appointment.
- ◆ If you wear contact lenses, we recommend that you remove them and wear your eyeglasses instead.
- ◆ **Remove nail polish and artificial nails from at least the index finger of each hand before your appointment.** This is very important for monitoring purposes during the procedure.

**IMPORTANT:**

**It is our office policy that parents, spouses or other family members are not allowed in the room during the patient's surgical procedure and must remain in the reception area during their surgery.**

Thank you again for calling us for your oral surgery needs. It is our goal to provide you only the highest quality care in a comfortable and safe atmosphere. If you have any questions that haven't been answered in this letter, we will be happy to address them at your consultation.

Sincerely,

Dr. Brent T. Garrison, Dr. Corbin G. Partridge, Dr. Patrick S. Kelly and the Staff

***For more information, visit our website at [www.neomsindy.com](http://www.neomsindy.com).***

- **Learn about our office** and the surgical procedures and other services our office provides.
- **Find information on the preoperative consultation**, scheduling, financial options, insurance, anesthesia options, and preoperative and post surgical instructions. (See the *Patient Information* link.)
- **Complete your Patient History form** on-line. Please complete and submit the form **at least 48 hours before your appointment**. We recommend you bring a print-out of the pages you submitted on-line when you visit the office.
- **Locate our office**. Our website has a link to provide driving directions from any location, i.e. your home or office address.

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY



## Patient Information

page 1

Mr. Mrs. Ms. Miss Dr. \_\_\_\_\_  
First MI Last Nickname  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_  
SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: Male Female Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Single Married Widowed Divorced  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Your Dentist \_\_\_\_\_ Physician \_\_\_\_\_ Orthodontist \_\_\_\_\_  
Who referred you to our office? Dentist Physician Orthodontist Friend \_\_\_\_\_ Other \_\_\_\_\_  
Have you or any family member been a patient at this office before?  no  yes If yes, what year? \_\_\_\_\_  
Who \_\_\_\_\_ Relationship \_\_\_\_\_  
Is patient a full-time student?  no  yes Name of School \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Is someone other than the patient responsible for this account?  no  yes If yes, please complete the following information:

Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

### PRIMARY INSURANCE COVERAGE INFORMATION

#### PRIMARY DENTAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Daytime Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_  
Employer Name \_\_\_\_\_ Group # \_\_\_\_\_ (List secondary dental insurance on page 2.)

#### PRIMARY MEDICAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insured Daytime Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_  
Employer Name \_\_\_\_\_ Group # \_\_\_\_\_ (List secondary medical insurance on page 2.)

I understand in signing this statement that I am financially responsible to Northeast Oral & Maxillofacial Surgery (NEOMS) for all fees incurred and all costs of collection, including but not limited to service, collection, collection agency, and attorney charges, if necessary. I hereby authorize the insured's insurance company to pay directly to NEOMS any and all of the benefits otherwise payable to me. I further authorize the release of health care information for the purpose of evaluating and administering claims for benefits.

Patient Signature or Parent/Guardian if Patient is a Minor

Printed Name

Date



## Patient Information

page 2

First

MI

Last

Nickname

### SECONDARY INSURANCE COVERAGE INFORMATION

#### SECONDARY DENTAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### SECONDARY MEDICAL INSURANCE

copy of card

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### AUTOMOBILE ACCIDENT

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

#### WORKERS COMPENSATION

Insurance Co. Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Insured Daytime Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Plan ID (if other than SSN#) \_\_\_\_\_

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_

**Accident/Workers Compensation Information** (Please describe how your accident occurred.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY



## Medical History

Patient Name: \_\_\_\_\_  
First
MI
Last
Nickname

Reason for today's office visit: \_\_\_\_\_

	Yes	No	Notes
Are you in good health?			
Height _____   Weight _____   Age _____			
Are you under the care of a physician? If yes, date of last visit _____			
For what were you being treated?			
Have you ever had any illness or been hospitalized?			
If yes, please explain: _____			

Please indicate if you have had any of the following conditions:							
	Yes	No	Notes		Yes	No	Notes
Heart Disease				Radiation Treatment			
Chest Pains				Anemia			
Heart Murmur				Bleeding Problems			
Mitral Valve Prolapse				Stomach Ulcers			
Rheumatic Fever				HIV or AIDS			
High Blood Pressure				Tumors/Growths			
Artificial Heart Valve				Chemotherapy			
Pacemaker				Hepatitis or Jaundice			
Stroke				Diabetes			
Bruising				Thyroid Disease			
Glaucoma				Kidney Disease			
Fainting Spells				Arthritis			
Chronic Fatigue				Artificial Joints			
Asthma				Seizures (Epilepsy)			
Lung Disease				Cancer			
Tuberculosis				Swollen Ankles			
Hay Fever/Sinus				Liver Disease			
Shortness of Breath				Alcohol/Drug Abuse			
Snoring				Delayed Healing			

	Yes	No	Notes
Are you allergic to anything (ie. latex, tape, antibiotics or pain medications)? If yes, please list:			
Are you currently taking any drugs or medications? If yes, please list:			
Have you ever had any adverse reaction to an anesthetic? If yes, please list:			
Have you ever had or been treated for clicking or pain in your jaw joint (TMJ)? If yes, please list:			
Have you ever had any unusual problems with previous dental work? If yes, please list:			
Is this visit a result of an accident? If yes, please list:			
Do you smoke?			
Have you ever taken diet pills (ie. Fen-Phen or Redux)?			
Are you taking any herbal medications (ie. St. John's Wort)?			
Women: Are you taking birth control pills?			
Are you pregnant?			
Are you nursing?			
Do you have any other conditions or problems we should know about prior to treatment? If yes, please list:			
Do you have any history of family diseases that we should know about? If yes, please list:			

I hereby certify that the above information is accurate and complete to the best of my knowledge.

Patient or Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# NORTHEAST ORAL & MAXILLOFACIAL SURGERY

## STATEMENT OF FINANCIAL RESPONSIBILITY

We understand that the financial aspects of healthcare can be difficult to understand and confusing. Our office will try to do everything we can to help you. If you provide us accurate and current insurance information, we will be happy to file your charges with your primary and secondary insurance companies. **We ask that you bring proof of coverage (insurance ID card or insurance forms) at the time of your appointment.** These documents will provide essential information that will help us determine the special requirements of your insurance plan, such as how often you may be treated and who may provide treatment to you and any family members covered by your plan. Please take time to review the following checklist that will help you provide us all of the necessary information at your appointment.

### If you have health insurance:

- Determine whether or not Dr. Garrison, Dr. Partridge, or Dr. Kelly is a participating provider of your insurance plan.
  - If your insurance company requires a referral from your dentist or physician, please bring a copy of the referral with you to your appointment.
  - Check if your insurance plan requires prior authorization as a requirement for benefits to be paid. If so, you may need to contact your insurance company prior to your appointment.
  - If your insurance coverage requires a co-pay at the time of service, please be prepared to pay that amount on the day of your appointment.
- You may call our office if you would like an estimate of the payment that will be due the day of your appointment.
  - As a courtesy, we will submit the initial claim to your insurance company for services we provide you.
  - You will receive a statement as long as your account has a balance unless you are a Medicare/Medicaid patient, Worker's Comp patient, or an automobile accident patient.
  - You will be responsible for all charges your insurance company does not cover due to unpaid deductibles, coinsurance, or non-covered services.

### If you do not have insurance coverage or if non-covered services are provided:

- Please call our office to obtain an estimate of charges for the services you plan to have done at your appointment.
- We accept cash, checks, and Visa, Mastercard, Discover & Care Credit.

I have read and understand the statement of financial responsibility above and agree to accept financial responsibility for all services provided by Dr. Garrison, Dr. Partridge, or Dr. Kelly as described.

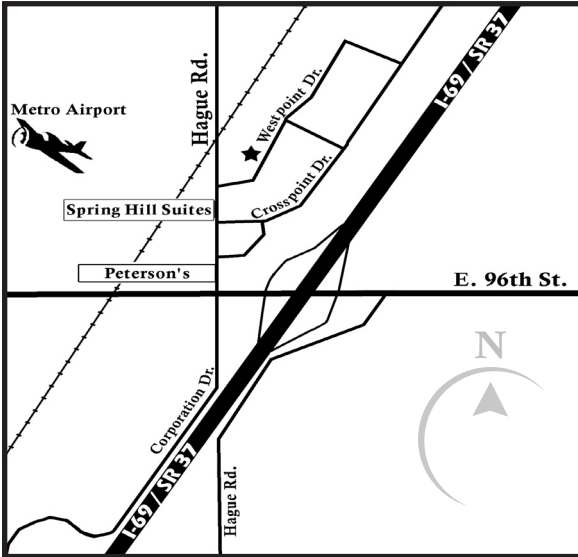
\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Printed Name

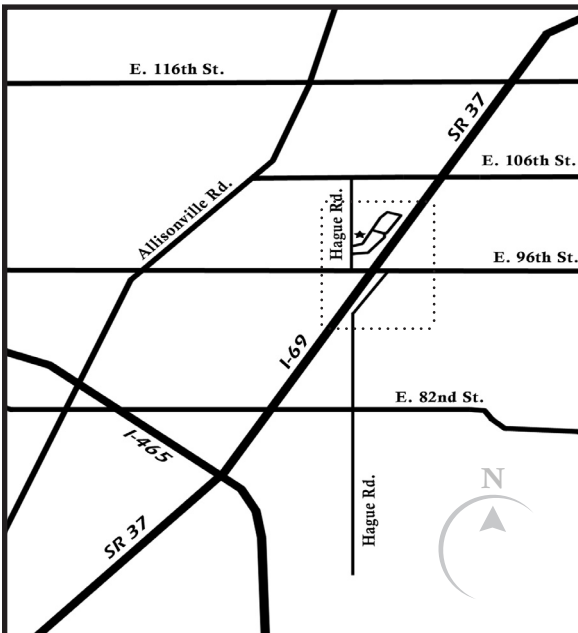
\_\_\_\_\_  
Date

Brent T. Garrison, D.D.S., M.S.D.  
Corbin G. Partridge, D.M.D.  
Patrick S. Kelly, D.D.S.

Northeast Oral & Maxillofacial Surgery  
9860 Westpoint Drive, Suite 100 . Indianapolis, IN 46256  
Phone 317-841-1100



**Directions from the south:**  
Take I-69 north, exit at 96th St. and turn left on 96th St. After you turn, immediately move to the far right lane and go to the second stop light and turn right (north) on Hague Rd., **located on the WEST SIDE of I-69.** Go to Westpoint Dr. and turn right. (Look for the Crosspoint complex entrance on the right, past the Spring Hill Suites Marriott.) Just around the curve, the office is on the left, located on the east side of the building in the center of the office complex, facing Westpoint Dr.



**Directions from the north:**  
Take I-69 south, exit at 96th St. and turn right on 96th St. Stay in the right lane and turn right (north) on Hague Rd., **located on the WEST SIDE of I-69.** Go to Westpoint Dr. and turn right. (Look for the Crosspoint complex entrance on the right, past the Spring Hill Suites Marriott.) Just around the curve, the office is on the left, located on the east side of the building in the center of the office complex, facing Westpoint Dr.