Brent T. Garrison, DDS, MSD
Robert P. Alderman, D.M.D.
Patrick S. Kelly, D.D.S.
Diplomates of the American Board of Oral & Maxillofacial Surgery

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. Robert P. Alderman, Dr. Patrick S. Kelly and the Staff

NORTHEAST ORAL & MAXILLOFACIAL SURGERY

Patient Information

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: ***Please Bring Insurance Care if Available***

☐ 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: ***Please Bring Insurance Card if Available***

☐ 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

NORTHEAST ORAL & MAXILLOFACIAL SURGERY

Patient Information

____
First MI Last Nickname

SECONDARY INSURANCE COVERAGE INFORMATION

SECONARY 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. Alderman, or Dr. Kelly is a particiating 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, American Express, Apple Pay, & 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. Alderman, or Dr. Kelly as described.

____ ______________

Patient's (or Legal Guardian's) Signature Printed Name Date

Revised 3-20

Northeast Oral and Maxillofacial Surgery

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures that we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Wendy S. Beard
(317) 841-1100 Fax: (317) 841-2200
9860 Westpoint Drive, Suite 100 Indianapolis, IN 46256

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE____

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: ________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

NOTICE OF PRIVACY PRACTICES

Northeast Oral & Maxillofacial Surgery

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.
Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices-We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosure of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy of your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization –The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosers - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g., a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

PRIVACY COMPLAINTS
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:
Telephone: (317) 841-1100 Fax: (317) 841-2200

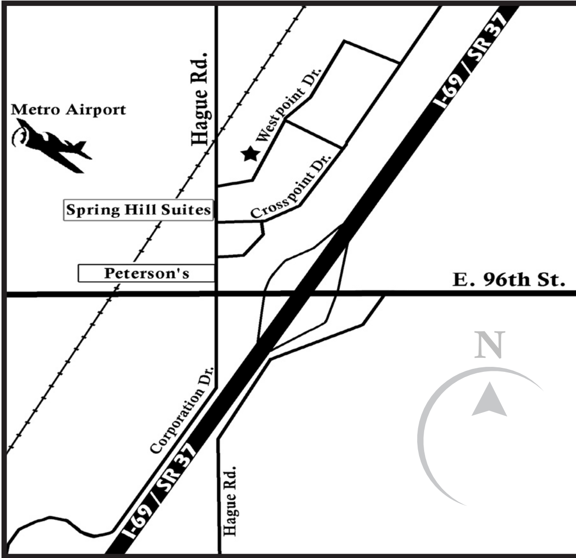
Email: wendy@neomsindy.com

Address: 9860 Westpoint Drive

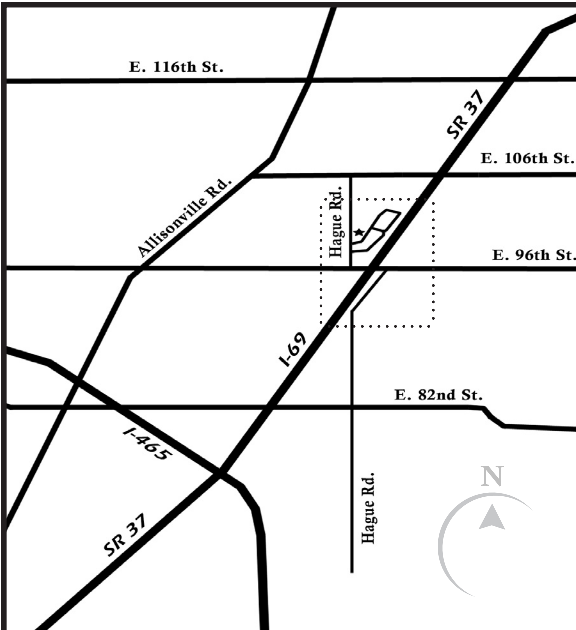
Indianapolis, IN 46256
We will not retaliate against you for filing a complaint.

Brent T. Garrison, D.D.S., M.S.D.
Robert P. Alderman, DMD
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.