Loeser
Oral, Maxillofacial & Implant Surgery

File # _____

All personal information is held in the strictest confidence.

Date _____

Patient Information:

First Name: _____ MI: ___ Last Name: _____ Title: _____

Nickname _____ Sex: _____ Spouse Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____

Email: _____

Birth Date: _____ Age: ____

Occupation: _____ School: _____

Have you been a patient of our practice before: _____

Insurance Information (if different from above)**:**

Who is responsible for this account: _____

First Name: _____ MI: ___ Last Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Cell Phone: _____

Birth Date: _____ Age: ____

Employer: _____

Referral Information:

Who referred you to our office: _____

Dentist: _____ Phone: _____

Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

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Medical History: Do you have or have you had any of the following?

Heart attack	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No	Autoimmune disorders	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Immune system deficiency	☐ Yes	☐ No
Kidnery failure / dialysis	☐ Yes	☐ No	Drug / alcohol addiction	☐ Yes	☐ No
Hepatitis / liver disease	☐ Yes	☐ No	Anxiety / psychiatric care	☐ Yes	☐ No
Stroke / CVA	☐ Yes	☐ No	Cancer / malignancy	☐ Yes	☐ No
Blood clots / DVT / PE	☐ Yes	☐ No	Site: _____		
Seizures / epilepsy	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Asthma / COPD	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No

☐ Yes ☐ No Have you ever taken drugs to treat osteoporosis (Fosamax, Zometa, Xgeva, Prolia)?

☐ Yes ☐ No Blood thinners (Coumadin, Plavix, Aspirin, Eliquis, Xarelto)?

☐ Yes ☐ No Smoke or vape? Quit? ☐ Yes ☐ No Year: _____

☐ Yes ☐ No Artificial joints (hip / knee / shoulder) ?

☐ Yes ☐ No Artificial heart valve?

☐ Yes ☐ No Pregnant or breastfeeding?

Illnesses or conditions not listed above:

Please list all current medications : (attach a sheet for long lists)

Please list all previous surgeries:

Please list any allergies (e.g. medicines, latex):

Patient Signature: _____ Date _____

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Primary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Primary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Secondary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Secondary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

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MEDICAL INFORMATION RELEASE FORM
(HIPAA FORM)

Name: _____ Birth Date: _____

Authorize:

☐ I authorize the release of information including the history, examination, diagnosis, and treatment rendered to me, and claims and billing information. This information may be released to:

- ☐ Spouse: _____
- ☐ Parents: _____
- ☐ Children: _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: ☐ Cell ☐ Home

If unable to reach me:

- ☐ Leave a detailed message
- ☐ Leave a message asking me to return your call
- ☐ Other: _____

Signature of patient / legal representative: _____ **Date:** _____

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Thank you for choosing James G. Loeser DDS, MD for the highest quality oral, maxillofacial and implant surgical care. To prevent misunderstanding concerning your responsibility regarding payment for services rendered, the following is understood:

Financial Policy: Both a social security number and a credit card on file is required. If you have benefits for the services that were provided, a claim will be submitted to your insurance company, Any remaining balance (resulting from deductible, co-insurance, etc.) is then **charged to your credit card on file.** After 60 days, unpaid balances will be turned over to a collection agency; the patient and/or patient guarantor is responsible for all collection costs.

PPO Dental/HMO: If you plan to use your insurance benefits, we will require a copy of your insurance card, a driver's license and your social security number. All co-payments are due prior to seeing the doctor. Failure to provide all necessary information may require you to pay in full on the date of the visit or subsequent to treatment. You are responsible for any services that are not a covered benefit under your insurance plan and/or are not considered medically necessary by the insurance company. Patient portions are due the day of surgery. There is a $25 processing fee for filing with your dental insurance. Please note: If services are not a covered benefit in your plan, the fees will not be reduced (per Illinois97th general assembly law SB3242).

PPO Medical: We are out of network with all medical insurance plans. Payment will be due in full for services rendered. If there is a payment issued to us from your insurance company, you will be reimbursed the amount issued.

Medicare: Dr. Loeser is NOT a Medicare provider. Dental services are NOT a covered benefit of Medicare. Fees are due in full the day of services.

Pathology Fees: If a specimen is taken, there will be a separate fee from the pathologist/independent pathology laboratory.

Self-Pay Patients: For patients without insurance, payment is due at the time of service.

Payments: Payments over 30 days are subject to a 3% fee.

Returned Checks: A charge of $50 will be made for all returned checks.

Payment Plans: Payment plans can be arranged PRIOR to services rendered. A credit card must be on file and will be run on specific dates. If your credit card information changes it is YOUR responsibility to contact us with the new information. If your card is declined, the balance will be due in full and the payment plan will be voided.

Appointment Cancellation Fee: If you are unable to keep your appointment, please call at least 24 hours in advance and speak with someone in our office or leave a message. Insufficient notice may subject you to a $20 fee.

My signature below indicates my understanding and full responsibly for the balance on my account for any professional services.

Signature of patient / legal representative: _____ **Date:** _____