Welcome to our Practice

Today's Date 04/28/2026

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(_____) _____

Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated Driver's Lic.# _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Student: ❑ Part-Time ❑ Full-Time ❑ Not

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

Insured Party S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Student: ❑ Part-Time ❑ Full-Time ❑ Not

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

Insured Party S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Student: ❑ Part-Time ❑ Full-Time ❑ Not

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

Insured Party S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Student: ❑ Part-Time ❑ Full-Time ❑ Not

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

Insured Party S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Patient Name _____

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? _____

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia or IV sedation?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring?			
24. Sleep apnea / CPAP?			
25. Difficult breathing / other lung trouble?			
26. Tuberculosis?			
27. COPD / emphysema?			
28. Blood transfusion?			
29. Blood disorder such as anemia?			
30. Bruise easily?			
31. Bleeding tendency / abnormal bleed?			
32. Hepatitis, jaundice, or liver disease?			
33. Gallbladder trouble?			
34. Fainting spells?			
35. Convulsions / epilepsy?			
36. Stroke?			
37. Thyroid trouble?			
38. Diabetes?			
39. Low blood sugar?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
41. Kidney trouble?			
42. High cholesterol?			
43. Are you on dialysis?			
44. Swollen ankles / arthritis / joint disease?			
45. Osteoporosis / osteopenia?			
46. Osteonecrosis?			
47. Stomach ulcer / acid reflux?			
48. COVID–19?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Autoimmune disease?			
53. Delay in healing?			
54. A tumor or growth?			
55. Cancer / radiation therapy / chemotherapy?			
56. Chronic fatigue / night sweats?			
57. Eye disease / glaucoma?			
58. Mental health problems / anxiety / depression?			
59. Developmental disability / autism spectrum disorder?			

SOCIAL HISTORY:	YES	NO	NOTES
60. Do you smoke or vape? If so, how much a day _____			
61. Do you use chewing tobacco?			
62. Alcohol intake? If so, drinks per Day _____ Week _____			
63. Is there a history / treatment for an alcohol use disorder?			
64. Is there a history / treatment for a marijuana or substance use disorder?			

Patient Name _____

WOMEN ONLY: *(QUESTIONS 65–68)*

	Yes	No
65. Is there a possibility of pregnancy?	❑	❑
66. Expected delivery date? _____		
67. Are you nursing?	❑	❑
68. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
69. Any kind of medication, drug, pills?			
70. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
71. Have you ever taken diet pills including GLP-1's for diabetes or weight loss (Trulicity, Ozempic, Byetta, Victoza, Rybelsus, Mounjaro, Wegovy, Saxenda etc)?			
72. Any natural product, herbal supplement or homeopathic remedy?			
73. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista?			

74. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

75. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other _____

Treating doctor: _____

76. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
77. Local anesthetic (numbing meds.)?			
78. Penicillin / amoxicillin?			
79. Other antibiotics?			
80. Sulfa drugs?			
81. Sodium pentothal / Valium / other tranquilizers?			
82. Aspirin?			
83. Codeine or other narcotics?			
84. Latex?			
85. Soy?			
86. Eggs / yolk?			
87. Sulfites?			
88. Do you have any known allergies?			

89. Please list any allergies other than drug allergies:

90. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

Patient Name _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

POLICY FOR APPOINTMENTS INVOLVING SURGERY

The day of your appointment, if you are having surgery, there may be driving and / or eating restrictions. The office will review this information with you prior to your procedure. I acknowledge that I have read and I understand the policy above.

X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

SAME-DAY CANCELLATION & NO-SHOW POLICY

We are committed to providing each patient with exceptional care. Surgical appointments, especially those involving IV sedation, require detailed preparation, coordination, and dedicated surgical suite time. As a result, we kindly ask that you review and respect the following cancellation policy:

CANCELLATION & NO-SHOW FEES

IV Sedation & Surgical Appointments

- Cancellations or rescheduling made less than 24 business hours in advance will result in a $250 fee.
- This applies to appointments involving IV sedation, extractions, implants, and other major procedures.

CONSULTATIONS & NON-SURGICAL APPOINTMENTS

- Cancellations made less than 24 business hours in advance may result in a $50 fee, depending on the appointment type.

WHY THIS POLICY MATTERS

When appointments are missed or canceled at the last minute, the time reserved for you cannot always be filled. This affects not only our team but also patients who may be waiting for time-sensitive treatment.

EXCEPTIONS

We understand that emergencies happen. Please call us as soon as possible-exceptions may be made at the discretion of our team.

TO CANCEL OR RESCHEDULE

Please call us at: 317.876.1095 during regular business hours. Messages left after hours will be considered received the following business day.

I have read and understand the Same-Day Cancellation & No-Show Policy. I acknowledge that fees may be charged if I fail to cancel within the required notice period.

Thank you for understanding and helping us continue to provide excellent care to all of our patients.

X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Patient name** **Date**

FEES & PAYMENTS

Welcome to our practice! Your health is our main concern, and it is our priority to help you reach your optimum dental health. Additionally, we will attempt to make payment for your oral surgery services as convenient as possible.

PAYMENT IS REQUIRED AS SERVICES ARE RENDERED

We accept all major credit cards, Care Credit, cash and certified checks.

A. If you have dental insurance, we will request a copy of your dental benefits insurance card. You are responsible for providing all insurance information for billing purposes.
B. Pre-treatment estimates provided are an estimate only and are subject to change depending on what your insurance final processes and pays. You are responsible for any balance and/or copayment indicated by your insurance policy at the time services are rendered.

PLEASE INDICATE HOW YOU WISH TO PAY YOUR ACCOUNT (CHOOSE ONE)

- ❑ I agree to pay all fees and treatment at the time services are rendered (no dental insurance to bill).
- ❑ I agree to pay the estimated pre-treatment balance due at the time of service and to bill the remaining charges to my dental insurance(s) for final processing.

I authorize Oral Surgeons of Indiana to keep my credit card information on file and to charge this card for any balances due on my account, including but not limited to co-pays, deductibles, treatment fees, missed appointment fees, or any unpaid balances after insurance processing. I understand that: I will be notified of charges when applicable; I am responsible for keeping my payment information up to date; This authorization will remain in effect until I provide written notice to cancel it.

I agree to pay for all professional fees and treatment at the time of service and/or the estimate co-payment amount not covered by my insurance. I realize that I am also responsible for full payment of balance not covered by insurance within 30 days from the date of service. I also agree to pay any interest accrued on any balance over 45 days from the date of service. I further agree to pay any collection agency fees, attorney fees, and court costs should these means of collection be necessary. I hereby authorize payment to Oral Surgeons of Indiana/Dr(s) Richard J. Stuart III, Dr. Denise Flanagan and Dr. Michael Wirey of group insurance otherwise payable to me.

X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Name of responsible party** **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ X _____ X _____

Signature of patient *(Parent or Guardian if Minor)* **Doctor** **Date**

Patient Name _____

PATIENT DISCLOSURE INSTRUCTIONS

Patient Name _____

❑ OK to leave a message with detailed Information on any phone numbers listed on your patient profile paperwork.
❑ OK to mail to my home address.

I allow you to give my clinical Information to or answer clinical related questions from: (Please check all that apply)

❑ Spouse/Partner _____
❑ Parent _____
❑ Child _____
❑ Other (Please specify) _____

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**

ACKNOWLEDGEMENT OF RECEIPT HIPAA NOTICE OF PRIVACY PRACTICES

You may refuse to sign

(Please print your name) I, _____, have seen Oral Surgeons of Indiana's Notice of Privacy Practices.

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**