Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date ______________

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ______________ M.I.____ Last Name ______________ Nickname ______________

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

Street ______________ City ______________ State _____ Zip ______________

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

Dentist ______________ Medical Doctor ______________ Referred By ______________

Driver's Lic.# ______________ Nearest relative not living with you ______________ Tel.(_____) ______________

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

Who will be responsible for your account?

(If self, skip to next section) ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ______________

Name ______________ S.S.# ______________ Birth Date ______________ Age _____ Tel.(_____) ______________

Street ______________ City ______________ State _____ Zip ______________

Employer ______________ Bus. Tel.(_____) ______________

Spouse or other guarantor information (*if different from above*)

Name ______________ Relation ______________ S.S.# ______________ Tel.(_____) ______________

Street ______________ City ______________ State _____ Zip ______________

Employer ______________ Bus. Tel.(_____) ______________

INSURANCE INFORMATION

1.I0

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address ______________

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ______________

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

❶

1.I1

Employer ______________
Bus. Address ______________
Bus. Tel.(_____) ______________ Plan ______________
Ins. Co. Name ______________
Address ______________
______________ Tel.(_____) ______________
Group # ______________ **Group Name** ______________
Insured Party ______________ Relation ______________
Sex: ❑ M ❑ F Birth Date ______________
Street ______________
City, State, Zip ______________
Tel.(_____) ______________ S.S. # ______________
I.D. # ______________

PRIMARY MEDICAL INSURANCE COMPANY

Employer ______________
Bus. Address ______________
Bus. Tel.(_____) ______________ Plan ______________
Ins. Co. Name ______________
Address ______________
______________ Tel.(_____) ______________
Group # ______________ **Group Name** ______________
Insured Party ______________ Relation ______________
Sex: ❑ M ❑ F Birth Date ______________
Street ______________
City, State, Zip ______________
Tel.(_____) ______________ S.S. # ______________
I.D. # ______________

SECONDARY DENTAL INSURANCE COMPANY

❷

1.I1

Employer ______________
Bus. Address ______________
Bus. Tel.(_____) ______________ Plan ______________
Ins. Co. Name ______________
Address ______________
______________ Tel.(_____) ______________
Group # ______________ **Group Name** ______________
Insured Party ______________ Relation ______________
Sex: ❑ M ❑ F Birth Date ______________
Street ______________
City, State, Zip ______________
Tel.(_____) ______________ S.S. # ______________
I.D. # ______________

SECONDARY MEDICAL INSURANCE COMPANY

Employer ______________
Bus. Address ______________
Bus. Tel.(_____) ______________ Plan ______________
Ins. Co. Name ______________
Address ______________
______________ Tel.(_____) ______________
Group # ______________ **Group Name** ______________
Insured Party ______________ Relation ______________
Sex: ❑ M ❑ F Birth Date ______________
Street ______________
City, State, Zip ______________
Tel.(_____) ______________ S.S. # ______________
I.D. # ______________

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication 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
99. Are you in good health? Height Weight	❑	❑
100. Have there been any changes in your general health in the past year?	❑	❑
101. Are you under the care of a physician? Date of last visit *If so, for what are you being treated?*	❑	❑
102. Have you had any illness, operation or been hospitalized in the past five years? *If so, describe*	❑	❑
103. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, describe where*	❑	❑
104. Do you have a prosthetic joint/implant? *If so, describe where*	❑	❑
105. Have you had a heart valve replacement or vascular graft?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficult breathing / other lung trouble?			
121	Tuberculosis?			
122	Emphysema?			
123	Do you smoke?			
124	Do you use chewing tobacco?			
125	Blood transfusion?			
126	Blood disorder such as anemia?			
127	Bruise easily?			
128	Bleeding tendency / abnormal bleed?			
129	Hepatitis, jaundice, or liver disease?			
130	Infectious mononucleosis?			
131	Gallbladder trouble?			
132	Fainting spells?			
133	Convulsions / epilepsy?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
134	Stroke?			
135	Thyroid trouble?			
136	Diabetes?			
137	Low blood sugar?			
138	Kidney trouble?			
139	Are you on dialysis?			
140	Swollen ankles, arthritis or joint disease?			
141	Stomach ulcers?			
142	Contagious diseases?			
143	HIV / AIDS?			
144	Sexually transmitted diseases?			
145	Problems with the immune system?			
146	Delay in healing?			
147	A tumor or growth?			
148	Radiation therapy / chemotherapy?			
149	Chronic fatigue / night sweats?			
150	Are you on a diet?			
151	A history of drug abuse?			
152	A history of alcohol abuse?			
153	Contact lenses?			
154	Eye disease / glaucoma?			
155	Mental health problems?			
156	A removable dental appliance?			
157	Pain and clicking of jaws when eating?			
158	Malignant hyperthermia?			
159	**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
160	Who is driving you home?			

MEDICATION *Are you now taking. . .*		*Yes*	*No*	*NOTES*
201	Any kind of medication, drugs, or pills?			
202	Blood thinners (Coumadin, Aspirin, Advil)?			
203	Have you ever taken diet pills?			
204	Tranquilizers?			
205	Any natural product, herbal supplement or homeopathic remedy?			
206	Please list any other medications you are taking:			

WOMEN ONLY (220-223)		*Yes*	*No*	*NOTES*
220	Is there a possibility of pregnancy?			
221	Expected delivery date ____________			
222	Are you nursing?			
223	Are you taking birth control pills?			

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

ALLERGIES *Are you allergic to or had a reaction to. . .*		*Yes*	*No*	*NOTES*
207	Local anesthetic (numbing med.)?			
208	Penicillin?			
209	Other antibiotics?			
210	Sulfa Drugs?			
211	Sodium pentothal, Valium, or other tranquilizers?			
212	Aspirin?			
213	Codeine or other narcotics?			
214	Other medications?			
215	Latex?			
216	Soy?			
217	Eggs / Yolk?			
218	Sulfites?			
219	Please list any allergies other than drug allergies:			

Is there any condition concerning your health that the Doctor should be told about?

❑ Yes ❑ No *(if so, describe)* ______________________________

Do you wish to speak to the doctor privately about anything?

❑ Yes ❑ No

Is there a **FAMILY HISTORY** of:

301. **Cancer:**	❑ Yes ❑ No
302. **Diabetes:**	❑ Yes ❑ No
303. **Heart Disease:**	❑ Yes ❑ No
304. **Anesthetic Problems:**	❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name ______________________________

Home Tel.(______) ______________________

Bus. Tel.(______) ______________________

IS THIS VISIT RELATED TO AN ACCIDENT?

Automobile:	❑ Yes	❑ No
Work Related:	❑ Yes	❑ No
Other:	❑ Yes	❑ No

Date of Injury ____________________

Insurance company handling this claim ______________________

Claim number ______________________

Name of Attorney / Adjustor ______________________

Telephone Number (______) ______________________

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 surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

Fees and Payments

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs (a 35% fee of balance due), attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

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.

X **Date**

X **Signature of patient** *(Parent or Guardian if minor)*

Witness: X

Doctor: X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X