MONTVILLE ORAL SURGERY ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name _____ (Last / First / M.I.)
Address _____ (Street)
_____ (City / State / Zip)
Phone ( ) _____ Employer _____
Alternate Phone ( ) _____ Sex _____
Date of Birth _____ Age _____ Social Security No. _____
Reason For Visit _____
Referring Doctor _____
Send Bill To (if not patient) _____
Marital Status _____ Student Status _____
Pharmacy (name & location) _____ Phone ( ) _____
Emergency Contact _____ Phone ( ) _____

PRIMARY INSURANCE INFORMATION

Insured Individual _____ (Last / First / M.I.)
Address (if different) _____ (Street)
_____ (City / State / Zip)
Date of Birth _____ Social Security No. _____
Relationship To Insured _____
Employer _____ Work Phone No. ( ) _____
Employer Address _____
Insurance Company _____ Insurance Co. Phone No. _____
Full Insurance Co. Address _____
Insured's ID _____ Group No. _____

SECONDARY INSURANCE INFORMATION

Secondary Insured _____ (Last / First / M.I.)
Address (if different) _____ (Street)
_____ (City / State / Zip)
Date of Birth _____ Social Security No. _____
Relationship To Insured _____
Insurance Company _____ Insurance Co. Phone No. _____
Full Insurance Co. Address _____
Insured's ID _____ Group No. _____

I hereby assign the policy rights and benefits to the Doctor, and authorize direct payment for professional services rendered. I further authorize the attending Doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance or co-payment to the Doctor, and if I receive any payments from my insurance company in error, I will sign them directly over to the Doctor.

Patient Signature

_____

Date _____

MONTVILLE ORAL SURGERY, LLC

Diplomates of the American Board of
Oral and MaxillofacialSurgery
Dr. Frederick Ernst
Dr. Patrick Pirozzi

MEDICAL HISTORY FORM

Patient's Name: _____ Date: _____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation..... that has depressed your immune system? ..... Y N
   - S. HIV, AIDS or ARC? ..... Y N
   - T. Chemotherapy to treat any form of cancer (such as breast, prostate, lung or bone), multiple myeloma or bone tumors/disease? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N

Please Complete Other Side

H. Digitalis, Inderal, Nitroglycerin or other heart drug? ..... Y N

I. Any regular prescription medicine, pills or drugs ..... Y N
If Yes, please list_____
_____

J. Diet Pills..... Y N

K. Herbal or Holistic remedies, Vitamins or over-the-counter medications? ..... Y N
If Yes, please list:_____

L. Have you ever been treated by any form of bisphosphonate medication such as: Actonel, Boniva, Fosamax, Aredia, Zometa? ..... Y N

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

A. Local Anesthesia (Novocain, etc.)?..... Y N

B. Penicillin or other antibiotics?..... Y N

C. Sedatives, Barbiturates?..... Y N

D. Aspirin or Ibuprofen?..... Y N

E. Codeine or other pain killers? ..... Y N

F. Latex or Rubber Products? ..... Y N

G. Other allergies or reactions? Please, list..... Y N
_____
_____

10. Do you smoke or chew Tobacco? ..... Y N
How much per day? _____

11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N

12. Have you had any serious problems associated with any previous dental treatment? ..... Y N

13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N

15. Do you wish to talk to the doctor privately about anything?..... Y N

16. **FEMALES ONLY**

A. Are you Pregnant, or **is there any chance** you might be Pregnant?..... Y N

B. Are you nursing..... Y N

C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

_____ _____
Date Signature of Person Completing Health History
Doctor's Initials_____

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

_____ _____ _____
Date Exceptions or changes Patient's Signature
Doctor's Initials_____

_____ _____ _____
Date Exceptions or changes Patient's Signature
Doctor's Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, , have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

☐ I authorize release of medical information to the following individuals:

_____ _____

_____ _____

_____ _____

☐ I authorize the doctor/staff to leave medical information on an answering machine.

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

MONTVILLE ORAL SURGERY ASSOCIATES, L.L.C.

Diplomates Of The American Board Of Oral and Maxillofacial Surgery
Fellows American Association Of Oral And Maxillofacial Surgery

Frederick H. Ernst, D.M.D.
Specialty Lincense No. 3332

Patrick J. Pirozzi, D.M.D.
Specialty License No. 3438

INSURANCE UPDATE

Please be advised that this office (Montville Oral Surgery Associates) and its agents make no assurances, inferences, nor guarantees regarding your insurance coverage (medical, dental, HMO, PPO, etc.). Although we may participate with an insurance carrier, it is simply impossible for this office to be aware of, nor versed in, each particular plan's coverage, as there are a multitude of insurance plans and coverage particulars.

Our staff will do its best to provide you with the necessary information (such as diagnosis and treatment codes); however, it is incumbent upon you, the patient, to verify any insurance coverage regarding treatment in our office. It is your insurance coverage – it is your responsibility to ascertain benefits.

Certainly our staff will make every effort to assist with insurance questions. Each plan is different and the contract negotiated by your employer may contain restrictions that others do not. You are responsible to know these restrictions. We are aware of the many frustrations of the managed care system. However, we must work within the guidelines of your insurance company.

Thank you for your understanding.

_____ _____

Date Signature of Patient or Guardian

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