# Cherry Creek Oral Surgery - PATIENT INFORMATION FORM

Date:____________________

Title: (Mr., Mrs., Ms.) First Name ______________________ Middle Initial: ____ Last Name:______________________

Sex: ☐ Male ☐ Female Date of Birth: ______________________ Age:_____ Social Security No. ______________________

Street: ______________________________________________

City: ______________________ State____________________ Zip______________________

Home Tel.: (______) ______________________ Business Tel.: (______)______________________ Ext.________________

Physician: ______________________ Dentist:______________________

Employer: ______________________ Dentist Tel.: (______) ______________________

Student Full Time ☐ Part Time ☐ Non Student ☐ School/City: ______________________

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ Employed: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐

Referred By:______________________________________________

Who will be responsible for account? Relation: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐

Name:______________________ Home Tel.: (______) ______________________

Street:______________________ City:______________________State:_____Zip: ______________________

①

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**PRIMARY INSURANCE COMPANY:**

Name: ______________________

Address: ______________________

______________________

Phone: (______) ______________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group No.:________________Group Name ________________

Local:______________________

**INSURED PARTY:**

Name: ______________________

Date of Birth: ______________________

Street: ______________________

City, State, Zip: ______________________

Phone: (______) ______________________

Social Security No. ______________________

Patient relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

**EMPLOYER INFORMATION:**

Name: ______________________________________________

Street: ______________________ City:______________________ State:_______ Zip ________________

Is this an Employer Health Insurance Plan? ☐ Yes ☐ No Employer ID No.: ______________________

②

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**SECONDARY INSURANCE COMPANY:**

Name: ______________________

Address: ______________________

______________________

Phone: (______) ______________________

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group No.:________________ Group Name ________________

Local:______________________

**INSURED PARTY:**

Name: ______________________

Date of Birth: ______________________

Street: ______________________

City, State, Zip: ______________________

Phone: (______) ______________________

Social Security No.______________________

Patient relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

**EMPLOYER INFORMATION:**

Name: ______________________________________________

Street: ______________________ City:______________________ State:_______ Zip ________________

Is this an Employer Health Insurance Plan? ☐ Yes ☐ No Employer ID No.: ______________________

③

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**FEES AND PAYMENTS:**

We make every effort to keep down the cost of your oral surgery care. 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 at the top of the form.

Please remember that insurance is considered a method of reimbursing the patient for fees 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.

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

In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection cost and reasonable attorney's fees incurred to effect collection of this account or future outstanding accounts.

④

Signature: ______________________

Cherry Creek
Oral & Maxillofacial
Surgery, P.C.

# Patient Health History

Date ____________

Patient Name ______________________________________________ Age ______________ Sex _______

Height_____ft._____in. Weight__________lbs. Are you in good health?.................... ❑ Yes ❑ No

Have there been any changes in your general health in the past year? ......................... ❑ Yes ❑ No

If so, explain ____________________________________________________________

Are you under the care of a physician?........................................................................ ❑ Yes ❑ No

If so, for what are you being treated? ___________________________ Date of last visit____________

The name, address and phone number of my physician is:_____________________________________

_____________________________________________________

_____________________________________________________

Have you had any illness, operation or been hospitalized in the past five years?........... ❑ Yes ❑ No

____________________________________________________________________

Do you have any unhealed injuries or inflamed areas in or around your mouth? ........... ❑ Yes ❑ No

Do you have any growth or sore spots in your mouth? .................................................. ❑ Yes ❑ No

| HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . . | Yes | No | Notes | HAVE YOU HAD OR DO YOU CURRENTLY HAVE/USE . . . | Yes | No | Notes |
|---|---|---|---|---|---|---|---|
| 1 Rheumatic fever? | | | | 27 Convulsions, epilepsy? | | | |
| 2 Heart valve problems /mitral valve prolapse? | | | | 28 Stroke? | | | |
| 3 Heart Murmur? | | | | 29 Thyroid trouble? | | | |
| 4 Heart Problems? | | | | 30 Diabetes? | | | |
| 5 High blood pressure? | | | | 31 Low blood sugar? | | | |
| 6 Low blood pressure? | | | | 32 Kidney trouble? | | | |
| 7 Chest pain, angina? | | | | 33 Are you on dialysis? | | | |
| 8 Heart attack(s)? | | | | 34 Swollen ankles? | | | |
| 9 Irregular heart beat? | | | | 35 Arthritis or joint disease? | | | |
| 10 Cardiac pacemaker? | | | | 36 Stomach ulcers? | | | |
| 11 Heart surgery? | | | | 37 Contagious diseases? | | | |
| 12 Bronchitis, chronic cough? | | | | 38 Sexually transmitted diseases? | | | |
| 13 Asthma? | | | | 39 Problems of the immune system? | | | |
| 14 Hayfever/Sinus problems? | | | | 40 A tumor or growth? | | | |
| 15 Tuberculosis? | | | | 41 Mental health problems? | | | |
| 16 Emphysema? | | | | 42 Removable dental appliances? | | | |
| 17 Difficulty breathing? | | | | 43 Are you on a diet? | | | |
| 18 Any other lung trouble? | | | | 44 Alcoholic beverages? | | | |
| 19 Do you smoke? | | | | 45 Contact lenses? | | | |
| 20 Blood disorder such as anemia? | | | | 46 Eye disease/Glaucoma? | | | |
| 21 Bruise easily? | | | | 47 Radiation/chemotherapy? | | | |
| 22 Bleeding tendency (abnormal bleed)? | | | | 48 Blood transfusion? | | | |
| 23 Jaundice, hepatitis or liver disease? | | | | 49 Pain & clicking of jaws when eating? | | | |
| 24 Infectious mononucleosis? | | | | 50 Malignant Hyperthermia? | | | |
| 25 Gallbladder trouble? | | | | 51 TMJ Dysfunction? | | | |
| 26 Fainting spells? | | | | 52 HIV/AIDS? | | | |

*(Over)*

PLEASE LIST
MEDICATIONS

Are you taking any of the following?

- Anticoagulants/Blood Thinners ❑ Yes ❑ No
- Tranquilizers/Antidepressants (Elavil) ❑ Yes ❑ No
- Cortisone/Prednisone ❑ Yes ❑ No
- Antibiotics ❑ Yes ❑ No
- Aspirin ❑ Yes ❑ No
- Heart Medication ❑ Yes ❑ No
- Medicine for high blood pressure ❑ Yes ❑ No
- Insulin, Tolbutamide (Orinase) or similar drug ❑ Yes ❑ No
- Bisphosphonate, Fosamax, Actonel, Boniva ❑ Yes ❑ No
- Other ________________ ❑ Yes ❑ No

Do you have any artificial joints in your body? ❑ Yes ❑ No

Are you allergic to or have you reacted adversely to any drug including penicillin, novocaine, tetracycline, aspirin or codeine? ❑ Yes ❑ No

Other ________________ ❑ Yes ❑ No

Allergies other than drug allergies? *(please list)*
________________ ❑ Yes ❑ No

Do you have any disease, condition or problem not listed above that you think we should know about? ❑ Yes ❑ No

If so, please explain ________________

Have you had any serious problems with any previous dental treatment? ❑ Yes ❑ No

If so, explain ________________

________________

Have you or your family had any serious problems associated with general anesthesia or sedation? ❑ Yes ❑ No

If so, explain ________________

________________

Have you ever bled excessively after a cut, wound or surgery? ❑ Yes ❑ No

If so, please explain ________________

Women:

- Is there a possibility that you may be pregnant? ❑ Yes ❑ No
- If so, estimated delivery date ________________
- Are you nursing? ❑ Yes ❑ No
- Are you taking birth control pills? ❑ Yes ❑ No
- Do you have any problems associated with your menstrual period? ❑ Yes ❑ No
- If so, please explain ________________

If you are completing this form for the patient, what is your relationship to the patient? ________________

I certify that I have read and understand the 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 staff, responsible for any errors or omission that I may have made in the completion of this form.

Signature of patient: ________________ Date ________
(Parent or Guardian if Minor)

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**Office Use Only**

Reviewed by: ________ ________ ________ ________

Date: ________ ________ ________ ________

# Cherry Creek Oral & Maxillofacial Surgery, P.C.
# Dr. Clyde E. Waggoner
# Financial Policy

We are committed to providing you with the best care possible! We will be open in discussing our professional fees with you and hope that you have a clear understanding of our financial policy. This is important to our professional relationship and the understanding of your financial responsibilities.

We must emphasize that as health care providers, our relationship is with you, and not your insurance company.

•Your insurance is a contract between you, your employer and your insurance company.

•Patients covered under a PPO/HMO/EPO/POS plans are responsible for complying with the PPO/HMO/EPO/POS rules regarding written and telephone referrals from primary care dentist. Telephone confirmation of your co-payment is not necessarily a guarantee of payment.

•Failure to comply with the referral requirements of your plan will make it necessary for us to bill you directly for charges incurred during a non-referral visit.

•We will process claims with PPO/HMO/EPO/POS plans with which we have a contract agreement, according to each agreement.

•Required co-payments must be made on the day the service is provided.

Payment for service is due at the time the service is rendered, unless payment arrangements have been approved in advanced by our office. You are responsible for timely payment of your account. If for any reason you experience financial problems that may affect timely payment of your account, we encourage you to contact our office so arrangements can be made to help you maintain your account in good standing.

Thank you for understanding our financial policy. If you have any questions about the above information, please ask us to help you understand the above clearly. We are here to help you.

**I have read the above information; I understand and agree that I am responsible for the payment of all professional services rendered.**

____________________________ ______________________

Signature Date