Welcome To Our Practice

Date: _____

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Date of Birth _____ Age ____ Soc. Sec. # _____ Email (optional) _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (____) _____ Business Tel. # (____) _____ Ext. _____ Employer _____

Dentist _____ Medical Doctor _____ Referred By _____

Cell Phone # _____ Nearest relative not living with you _____ Tel. # (____) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account? ❑ **Self** ❑ **Spouse** ❑ **Father** ❑ **Mother** ❑ **Other** _____
(If self, skip to next paragraph)

Name _____ Soc. Sec. # _____ Home Tel. # (____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. # (____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ Soc. Sec. # _____ Home Tel. # (____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. # (____) _____

INSURANCE INFORMATION

Patient: 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

Employer _____

Bus. Address _____

Bus. Tel. # (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

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 Date of Birth _____

Street _____

City, State, Zip _____

Tel. # (____) _____ S.S. # _____

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. # (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

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 Date of Birth _____

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? _____ _____	❑	❑
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/when _____	❑	❑
105.	Have you had a heart valve replacement, vascular graft or stent? _____	❑	❑

	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 heartbeat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Tuberculosis?			
120	Emphysema?			
121	Difficult breathing / other lung trouble?			
122	Do you smoke?			
123	Blood transfusion?			
124	Blood disorder such as anemia?			
125	Bruise easily?			
126	Bleeding tendency (abnormal bleed)?			
127	Jaundice, hepatitis or liver disease?			
128	Infectious mononucleosis?			
129	Gallbladder trouble?			
130	Fainting spells?			
131	Convulsions, epilepsy?			
132	Stroke?			
133	Sleep Apnea?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES
134	Thyroid trouble?			
135	Diabetes?			
136	Low blood sugar?			
137	Kidney trouble?			
138	Are you on dialysis?			
139	Swollen ankles, arthritis or joint disease?			
140	Stomach ulcers?			
141	Contagious diseases?			
142	Sexually transmitted diseases?			
143	Problems with the immune system?			
144	Delay in healing?			
145	A tumor or growth?			
146	X-Ray treatment / chemotherapy?			
147	Chronic fatigue / night sweats?			
148	Are you on a diet?			
149	A history of drug abuse?			
150	A history of alcohol abuse?			
151	Contact lenses?			
152	Eye disease / glaucoma?			
153	Mental health problems?			
154	A removable dental appliance?			
155	Pain & clicking of jaws when eating?			
156	Malignant hyperthermia?			
157	Osteoporosis?			
158	Do you have a prosthetic joint/implant?			
159	Any other medical condition not listed?			
160	**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
161	Who is driving you home?			

MEDICATION

ARE YOU KNOW TAKING . . .	Yes	No		
201. Any kind of medicine, drugs, or pills?				203. Are you taking meds for Osteoporosis?
202. Please list any other medications you are taking:				

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO . . .	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO . . .	Yes	No	Notes
204. Local anesthetics?				211. Aspirin / Ibuprofen?			
205. Penicillin?				212. Codeine or other narcotics?			
206. Amoxicillin?				213. Other medications?			
207. Clindamycin?				214. Latex?			
208. Complications w/Anesthesia?				**215. Please list any allergies other than drug allergies:**			
209. Other antibiotics?							
210. Sodium pentothal, valuim, or other tranquilizers?							

WOMEN

216. Is there a possibility of pregnancy?				218. Are you nursing?			
217. Estimated delivery date? __/__/__				219. 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.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes ❑ No ❑

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 _____ Tel: H # (___) _____ Wk # (___) _____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: ❑ Yes ❑ No Work Related: ❑ Yes ❑ No Other: ❑ Yes ❑ No

Date of Injury _____ Insurance Co. handling this claim _____ Claim # _____

Name of Attorney / Adjustor _____ Tel # (___) _____

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: X _____ **Reviewed by:** X _____ **Date:** X _____
(Parent or Guardian if minor)

Fees & 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, 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.

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

Witness: X _____ **Doctor:** X