

Welcome to our Practice

PATIENT INFORMATION:

Today's Date _____

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 _____ Has a family member ever been a patient of our practice? Yes No
Dentist _____ Orthodontist _____ Medical Dr. _____
Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____
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 _____ 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 _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student: _____ Full Time Part Time Not _____ School Name and Address _____
Marital Status: Married Divorced Widowed Single Legally Separated _____
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 _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address _____

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe | | |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe where | | |
| 6. Do you have a prosthetic joint / implant? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe where | | |
| 7. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke? If so, number of packs a day _____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach ulcers / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of drug abuse?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

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

FEEES & PAYMENTS

We make every effort to keep down the cost of your 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.

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

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.

X _____ X _____
Signature of patient: (Parent or Guardian if Minor) 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.

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

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.

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