ANTHONY L. TORTORICH, D.D.S., P.A.

Oral & Maxillofacial Surgery

4220 N. Rodney Parham, Suite 103 • Little Rock, AR 72212
Telephone 501-224-8332

PATIENT INFORMATION Date _____

Patient's Name _____ Age _____ Date of Birth _____ Sex _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Telephone (Cell) _____

(Who referred you to our office?) _____

General Dentist _____ Orthodontist _____ Regular Physician _____

Have we ever seen any other immediate family members? _____ Name _____

Social Security Number _____ Marital Status _____

Are you a full-time student? ☐ Yes ☐ No If so, Where _____ City _____ State _____

IF PATIENT <u>IS NOT</u> A MINOR:

Patient's Occupation _____ Business Telephone _____

Employer's Name _____ Address _____

Spouse's Name _____ Business Telephone _____

Employer's Name _____ Address _____

IF PATIENT <u>IS</u> A MINOR or IS CARRIED UNDER PARENTS INSURANCE:

Father's Name _____ Business Telephone _____

Employer's Name _____ Address _____

Mother's Name _____ Business Telepone _____

Employer's Name _____ Address _____

Billing Party's Name & Address (If different from patient's address) _____

_____

ALL PATIENTS:

Name of relative NOT residing with patient, or friend if no relative _____

Relationship to patient _____ Telephone _____

Address of relative or friend _____

INSURANCE INFORMATION:

(Insurance Assignment of payments accepted, <u>but all accounts are due within 45 days regardless of Insurance</u>.)

Company Name _____ Company Name _____

I.D. No. _____ I.D. No. _____

Group _____ Group _____

The policy is in the name of: _____ The policy is in the name of: _____

Social Security # _____ Social Security # _____

How do you plan to pay for today's visit? Cash / Check ☐ VISA / MC / AMEX ☐ DISCOVER/NOVUS ☐

Have you ever filed for Bankruptcy, or are you in the process of filing bankruptcy? ☐ Yes ☐ No

For your convenience, we will be happy to file your claim on your primary and secondary insurance(s). Any additional filings will be the responsibility of the patient.

(CONTINUED ON BACK)

HEALTH HISTORY

	Yes	No
1. Are you in good health?	☐	☐
2. Are you now under the care of a physician?	☐	☐
a) If so, for what condition? _____		
3. Have you ever been hospitalized?	☐	☐
4. Have you ever been seriously ill?	☐	☐
5. Are you allergic to any medication?	☐	☐
a) If so, what? _____		
6. Are you taking any medications including herbal medications / supplements?	☐	☐
a) If so, what? _____		
7. Have you ever taken cortisone or similar drugs?	☐	☐
8. Have you ever had radiation therapy (other than routine x-rays)?	☐	☐
9. Women - are you pregnant?	☐	☐
10. Do you or does anyone in your family have a history of bleeding problems, or problems involving general anesthesia?	☐	☐
11. Have you had any serious trouble with previous dental treatment?	☐	☐
12. Do you have any reason to believe you may be immunosuppressed due to surgery or medications you are taking? (Chemotheraphy, transplant surgery, etc.)	☐	☐
13. Are you taking any medications for decreased bone density (osteoporosis)?	☐	☐
14. Have you ever had any blood transfusions?	☐	☐
15. Do you need to speak with the Doctor privately (away from family members) about anything?	☐	☐

16. Please check any of the following conditions which you have had or now have:

___ HIV / AIDS	___ Rhuematic Heart Disease	___ Diabetes
___ High Blood Pressure	___ Asthma	___ Sinusitis
___ Bronchitis	___ Emphysema	___ Tuberculosis
___ Epilepsy	___ Convulsions	___ Heart Surgery
___ Heart Attack	___ Heart Failure	___ Heart Murmur
___ Stroke	___ Chest Pain/Angina	___ Glaucoma
___ Hepatitis	___ Yellow Jaundice	___ Liver Disease
___ Cirrhosis	___ Any Blood Disease	___ Venereal Disease
___ Arthritis	___ Stomach Ulcers	___ Kidney Disease
___ Bladder Problems	___ Thyroid Gland Problems	___ Herpes Infection

I agree to be personally responsible for the payment of all services. If delinquent, I agree to pay for all collection and attorney fees that are required to obtain payment of the amount billed, and I further agree to pay all costs necessary that are incurred in connection therewith. If credit is extended, I agree to pay a finance charge at maximum allowable rates on the unpaid balance after 45 days. I understand that where appropriate, Credit Bureau Reports may be obtained.

I hereby authorize Anthony L. Tortorich, D.D.S., P.A., to furnish information to my insurance company concerning my care. I further assign all payments for medical services rendered to me or my dependents by the above. I understand, I am fully responsible for any portion of these services that are not covered by my insurance benefits.

I have received a copy and have had the opportunity to review this office's Notice of Privacy Practices.

_____

Patient Signature (Parent if minor) Date

We reserve the right to refuse to treat anyone.