Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date _____

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME) Referred By _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

(If self, skip to next section)

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

1.I0

Student: ❑ Full Time ❑ Part Time ❑ Not School Info _____ (SCHOOL NAME) _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP)

❑ 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

❶

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

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

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

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

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

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

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (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?	❑	❑
If so, describe ____		
103. Do you have unhealed/recurrent 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* ____	❑	❑
105. Have you had a heart valve replacement or vascular graft?	❑	❑

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 heart beat?			
114 Cardiac pacemaker?			
115 Heart surgery?			
116 Bronchitis, chronic cough?			
117 Asthma?			
118 Hay fever / sinus problems?			
119 Snoring / sleep apnea?			
120 Difficult breathing / other lung trouble?			
121 Tuberculosis?			
122 Emphysema?			
123 Do you smoke?			
124 Do you use chewing tobacco?			
125 Blood transfusion?			
126 Blood disorder such as anemia?			
127 Bruise easily?			
128 Bleeding tendency / abnormal bleed?			
129 Hepatitis, jaundice, or liver disease?			
130 Infectious mononucleosis?			
131 Gallbladder trouble?			
132 Fainting spells?			
133 Convulsions / epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
134 Stroke?			
135 Thyroid trouble?			
136 Diabetes?			
137 Low blood sugar?			
138 Kidney trouble?			
139 Are you on dialysis?			
140 Swollen ankles, arthritis or joint disease?			
141 Stomach ulcers?			
142 Contagious diseases?			
143 Sexually transmitted diseases?			
144 Are you immunosuppressed? possibly from transplant surgery, etc.			
145 Problems with the immune system? possibly from medication / surgery, etc.			
146 Delay in healing?			
147 A tumor or growth?			
148 Radiation therapy / chemotherapy?			
149 Chronic fatigue / night sweats?			
150 Are you on a diet?			
151 A history of drug abuse?			
152 A history of alcohol abuse?			
153 Contact lenses?			
154 Eye disease / glaucoma?			
155 Mental health problems?			
156 A removable dental appliance?			
157 Pain and clicking of jaws when eating?			
158 Malignant hyperthermia?			
159 **IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
160 Who is driving you home?			

MEDICATION – Are you now taking or have you taken. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
206	Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:			
207	Please list any medications you are currently taking:			

ALLERGIES – Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
208	Local anesthetic (numbing med.)?			
209	Penicillin?			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Valium, or other tranquilizers?			
213	Aspirin?			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolk?			
219	Sulfites?			
220	Please list any allergies other than drug allergies:			

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No ***(if so, describe)***

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 _____

Home Tel.(_____) _____

Bus. Tel.(_____) _____

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

Date of Injury _____

Insurance company handling this claim _____

Claim number _____

Name of Attorney / Adjustor _____

Telephone Number (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

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.*

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

FEES AND 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.

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

Witness: X

Doctor: X

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.

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

Print Form **Submit Form**