Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Date ______

❑ 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?

(If self, skip to next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ______

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

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

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ______ (CITY) ______ (STATE) ______ (ZIP)

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

❶

PRIMARY DENTAL 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. # ______

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. # ______

❷

SECONDARY DENTAL 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 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
Are you in good health? Height ____ Weight ____	❏	❏
Have there been any changes in your general health in the past year?	❏	❏
Are you under the care of a physician? Date of last visit ____	❏	❏
If so, for what are you being treated?		
Have you had any illness, operation or been hospitalized in the past five years?	❏	❏
If so, describe		
Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? *If so, describe where*	❏	❏
Do you have a prosthetic joint/implant? *If so, describe where*	❏	❏
Have you had a heart valve replacement or vascular graft?	❏	❏

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
Rheumatic fever?			
Damaged heart valves / mitral valve prolapse?			
Heart murmur?			
High blood pressure?			
Low blood pressure?			
Chest pain / angina?			
Heart attack(s)?			
Irregular heart beat?			
Cardiac pacemaker?			
Heart surgery?			
Bronchitis, chronic cough?			
Asthma?			
Hay fever / sinus problems?			
Snoring / sleep apnea?			
Difficult breathing / other lung trouble?			
Tuberculosis?			
Emphysema?			
Do you smoke?			
Do you use chewing tobacco?			
Blood transfusion?			
Blood disorder such as anemia?			
Bruise easily?			
Bleeding tendency / abnormal bleed?			
Hepatitis, jaundice, or liver disease?			
Infectious mononucleosis?			
Gallbladder trouble?			
Fainting spells?			
Convulsions / epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
Stroke?			
Thyroid trouble?			
Diabetes?			
Low blood sugar?			
Kidney trouble?			
Are you on dialysis?			
Swollen ankles, arthritis or joint disease?			
Stomach ulcers?			
Contagious diseases?			
Sexually transmitted diseases?			
Are you immunosuppressed? possibly from transplant surgery, etc.			
Problems with the immune system? possibly from medication / surgery, etc.			
Delay in healing?			
A tumor or growth?			
Radiation therapy / chemotherapy?			
Chronic fatigue / night sweats?			
Are you on a diet?			
A history of drug abuse?			
A history of alcohol abuse?			
Contact lenses?			
Eye disease / glaucoma?			
Mental health problems?			
A removable dental appliance?			
Pain and clicking of jaws when eating?			
Malignant hyperthermia?			
IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours?			
Who is driving you home?			

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

	Yes	No	NOTES
Any kind of medication, drug, pills?			
Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
Have you ever taken diet pills?			
Any natural product, herbal supplement or homeopathic remedy?			
Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			

Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:

Please list any medications you are currently taking:

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

	Yes	No	NOTES
Local anesthetic (numbing med.)?			
Penicillin?			
Other antibiotics?			
Sulfa Drugs?			
Sodium pentothal, Valium, or other tranquilizers?			
Aspirin?			
Codeine or other narcotics?			
Other medications?			
Latex?			
Soy?			
Eggs / Yolk?			
Sulfites?			

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:

Cancer:	❑ Yes ❑ No
Diabetes:	❑ Yes ❑ No
Heart Disease:	❑ Yes ❑ No
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