



# WELCOME TO OUR PRACTICE

Date \_\_\_\_\_

## PATIENT INFORMATION

1.1P

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

1.10

**Student:**  Full Time  Part Time  Not  Married  Divorced  Legally Separated  Widowed  Single  Retired

**Employed:**  Full Time  Part Time  Retired

School Info: SCHOOL NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Do you belong to a PPO or HMO?  Yes  No

## PRIMARY DENTAL INSURANCE COMPANY

1

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_

1.11

Ins. Co. Name \_\_\_\_\_

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 \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

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

1.11

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

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 \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Bus. Tel. (\_\_\_\_\_) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_

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 \_\_\_\_\_

- |  |                                    |              |                              |                             |
|--|------------------------------------|--------------|------------------------------|-----------------------------|
| 99. Are you in good health? _____  | Height _____                       | Weight _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 100. Have there been any changes in your general health in the past year? _____                                      |                                    |              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 101. Are you under the care of a physician? _____  | Date of last visit _____           |              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| <i>If so, for what are you being treated?</i> _____  |                                    |              |                              |                             |
| 102. Have you had any illness, operation or been hospitalized in the past five years? _____                          |                                    |              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| <i>If so, describe</i> _____   |                                    |              |                              |                             |
| 103. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? _____ | <i>If so, describe where</i> _____ |              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 104. Do you have a prosthetic joint/implant? <i>If so, describe where</i> _____                                      |                                    |              | <input type="checkbox"/>     | <input type="checkbox"/>    |
| 105. Have you had a heart valve replacement or vascular graft? _____   |                                    |              | <input type="checkbox"/>     | <input type="checkbox"/>    |

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	<b>IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours?</b>			
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:  \_\_\_\_\_ Reviewed by:  \_\_\_\_\_ Date:  \_\_\_\_\_

(Parent or Guardian if minor)

**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:  \_\_\_\_\_ Date:  \_\_\_\_\_

(Parent or Guardian if minor)

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:  \_\_\_\_\_ Date:  \_\_\_\_\_

(Parent or Guardian if minor)

**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.

\_\_\_\_\_  \_\_\_\_\_ **Witness:**  \_\_\_\_\_

**Date** **Signature of patient** (Parent or Guardian if minor) **Doctor:**  \_\_\_\_\_

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:  \_\_\_\_\_ Date:  \_\_\_\_\_

(Parent or Guardian if minor)