

PATIENT INFORMATION

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

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

If patient is a minor, give name of parent or legal guardian _____

Street _____ City _____ State _____ Zip _____

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

Dentist _____ Medical Doctor _____ Whom may we thank for referring you? _____

Student: Full Time Part Time Not **School Name** _____

Marriage Status: Married Divorced Legally Separated Widow Single **Employed:** Full Time Part Time Retired Not

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (If self, skip to next section)

Self Spouse Father Mother Other _____

Name _____ Birth Date _____ Age _____ Soc. Sec. # _____

Home Tel: (____) _____ Cell: (____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (____) _____

INSURANCE INFORMATION (If different from guarantor information in previous section)

MEDICAL INSURANCE: Name of Primary Subscriber _____ Relation _____

Birth Date _____ Soc. Sec. # _____

DENTAL INSURANCE: Name of Primary Subscriber _____ Relation _____

Birth Date _____ Soc. Sec. # _____

HEALTH HISTORY

To our patients: Although oral and maxillofacial surgeons primarily treat the areas 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 receive here. Thank you for answering the following questions. Your answers are for our records only and will be kept confidential.

REASON FOR TODAY'S OFFICE VISIT: _____	YES	NO
▪ Are you in good health? Height _____ Weight _____	<input type="checkbox"/>	<input type="checkbox"/>
▪ Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
▪ Are you under the care of a physician? _____ Date of last visit _____ <i>If so, for what are you being treated? _____</i>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Have you had any illness, operation or been hospitalized in the past five years? _____	<input type="checkbox"/>	<input type="checkbox"/>
▪ Do you have any 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"/>
▪ Do you have a prosthetic joint/implant? <i>If so, describe where _____</i>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Have you had a heart valve replacement or vascular graft? _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION – Are you now taking. . .	YES	NO
Any kind of medication, drug, pills?		
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)?		
Any natural product, herbal supplement or homeopathic remedy?		
Any bone density medications / bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?		
Have you ever taken tranquilizers, sleeping pills, antidepressants, and / or narcotics on a regular basis? <i>If so, please list:</i>		
Please list any medications you are currently taking:		

ALLERGIES – Are you allergic to. . .	YES	NO
Penicillin?		
Other antibiotics?		
Sulfa Drugs?		
Codeine or other narcotics?		
Other medications?		
Latex?		
Eggs / Yolk?		
Sulfites?		
Please list any other drug or non-drug allergies:		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .

	YES	NO		YES	NO		YES	NO
Rheumatic fever?			Do you use chewing tobacco?			Problems with the immune system? (possibly from medication / surgery, etc.)		
Damaged heart valves / mitral valve prolapse?			Blood disorder such as anemia?			Delay in healing?		
Heart murmur?			Bruise easily?			A tumor or growth?		
High blood pressure?			Bleeding tendency / abnormal bleed?			Radiation therapy / chemotherapy?		
Low blood pressure?			Hepatitis, jaundice, or liver disease?			Chronic fatigue / night sweats?		
Chest pain / angina?			Infectious mononucleosis?			Are you on a diet?		
Heart attack(s)?			Fainting spells?			A history of drug abuse?		
Irregular heart beat?			Convulsions / epilepsy?			A history of alcohol abuse?		
Cardiac pacemaker?			Stroke?			Contact lenses?		
Heart surgery?			Thyroid trouble?			Eye disease / glaucoma?		
Bronchitis, chronic cough?			Diabetes?			Mental health problems?		
Asthma?			Low blood sugar?			A removable dental appliance?		
Hay fever / sinus problems?			Kidney trouble or dialysis?			Pain and clicking of jaws when eating?		
Snoring / sleep apnea?			Swollen ankles, arthritis or joint disease?			Malignant hyperthermia?		
Difficulty breathing / lung disease?			Stomach ulcers?			IF YOU ARE HAVING GENERAL ANESTHESIA TODAY, have you had anything to eat or drink in the last 6 hours?		
Tuberculosis?			Contagious diseases?				Who is escorting you home? :	
Emphysema?			Sexually transmitted diseases?					
Do you smoke?			Are you immunosuppressed? (possibly from transplant surgery, etc.)					

Is there a FAMILY HISTORY of:	YES	NO
Cancer?		
Diabetes?		
Heart Disease?		
Anesthetic Problems?		

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

FOR WOMEN ONLY:	YES	NO
Is there a possibility of pregnancy?		
Expected delivery date:		
Are you nursing?		
Are you taking birth control pills?		
<p>Please 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.</p>		

IN CASE OF EMERGENCY, CONTACT:

Name _____ Home Tel: (____) _____ Cell: (____) _____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral and maxillofacial surgical care. You can help by paying upon completion of each visit. 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 complete the proper forms, but please fill out 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: **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: **X** _____ Date: **X** _____

AUTHORIZATION

I authorize my surgeon and his 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.

I certify that I have read and 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 staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **X** _____ Date: **X** _____