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 _____ Medical Doctor _____ Referred By _____

Driver's Lic.# _____ Nearest relative not living with you _____ 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 _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

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

Name _____ Relation _____ S.S.# _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION

1.IO

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address _____

❑ 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 _____

Bus. Tel.(_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

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

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

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

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

1.I1

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

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

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

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 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 HIV / AIDS?			
144 Sexually transmitted diseases?			
145 Problems with the immune system?			
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. . .		Yes	No	NOTES
201	Any kind of medication, drugs, or pills?			
202	Blood thinners (Coumadin, Aspirin, Advil)?			
203	Have you ever taken diet pills?			
204	Tranquilizers?			
205	Any natural product, herbal supplement or homeopathic remedy?			
206	Please list any other medications you are taking:			

ALLERGIES

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

WOMEN ONLY (220-223)

		Yes	No	NOTES
220	Is there a possibility of pregnancy?			
221	Expected delivery date _____			
222	Are you nursing?			
223	Are you taking birth control pills?			

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.

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 (_____) _____

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

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

PATIENT: DO NOT WRITE BELOW THIS LINE!

R 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 L
R 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17 L

Permanent

R a b c d e | f g h i j L
R t s r q p | o n m l k L

Deciduous

bp____ T____ P____

Exam & Consult

Head, Neck, Face:

Oral Soft Tissue:

Maxilla, Mandible:

Teeth, Occlusion:

T.M. Joints: