

Welcome

Welcome

Welcome

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 _____ 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

1.1O

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

1

1.11

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. # _____

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

2

1.11

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 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 _____

- | | | |
|--|------------------------------|-----------------------------|
| 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 _____
<i>If so, for what are you being treated?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 102. Have you had any illness, operation or been hospitalized in the past five years? _____
<i>If so, describe</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 103. Do you have unhealed 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	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		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		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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
302. Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
303. Heart Disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No
304. Anesthetic Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Date of Injury _____ Other: Yes No

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: _____ 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: (Parent or Guardian if minor) _____ Date: _____

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) _____ Date: _____

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) _____ Date: _____

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	a	b	c	d	e	f	g	h	i	j	L						
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17			t	s	r	q	p	o	n	m	l	k							
Permanent																bp____ T____ P____										Deciduous									
Exam & Consult																																			
Head, Neck, Face:																																			
Oral Soft Tissue:																																			
Maxilla, Mandible:																																			
Teeth, Occlusion:																																			
T.M. Joints:																																			