

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____ Date of Birth _____
 Age _____ Male Female Social Security Number _____ - _____ - _____ Single Married Divorced Separated Widowed
 Home Address _____ City _____ State _____ Zip Code _____
 Home Tel (_____) _____ Alternate Phone Work Cell (_____) _____ Ext _____
 Email _____ I prefer to be contacted by Home phone Cell phone Work phone Email
 Employer _____ Occupation _____ Full Time Part Time
 Address _____ City _____ State _____ Zip Code _____
 Dentist _____ Physician _____
Referred By: Dentist Other _____

PRIMARY INSURANCE

Insurance Company _____ Member's Name _____
 Address _____ Address _____
 Telephone (_____) _____ Relation to Patient: Self Spouse Parent Other
 Does Your Plan Cover Dental Medical Both Member's Social Security Number _____ - _____ - _____
 Employer _____ Group Number _____ Member's Date of Birth _____

ADDITIONAL INSURANCE

Insurance Company _____ Member's Name _____
 Address _____ Address _____
 Telephone (_____) _____ Relation to Patient: Self Spouse Parent Other
 Does Your Plan Cover Dental Medical Both Member's Social Security Number _____ - _____ - _____
 Employer _____ Group Number _____ Member's Date of Birth _____

FEES AND PAYMENTS

Your health and well being are our primary concern. We strive to provide the highest quality of Oral and Maxillofacial Surgery care to our patients. Therefore, we consider it important for you, our patient, to fully understand the treatment planned for you, the fees involved, as well as our office policy regarding payment of fees. We are happy to work with your insurance carrier to maximize your insurance benefits however, you are responsible for all fees charged by our office. We will be glad to submit the proper insurance forms on your behalf. Although insurance will generally reduce the overall cost to you, it will not eliminate it completely. Some companies pay a fixed allowance for services, while others pay a percentage of the fee charged.

After 60 days any outstanding balance will be your sole responsibility, regardless of any insurance pending. Accounts over 60 days will be assessed finance charges equal to the greater of 1.5% or \$5.00 per month.

I understand and agree to abide by the above stated policy. I hereby authorize payment of insurance benefits and the release of information necessary to process any claim to Spiro C. Karras, DDS.

Name of person responsible for account: _____

Signature: _____

Date: _____

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 you may have or medications that you may be taking may have an important bearing in the care that you will be receiving. Thank you for assisting us in providing you with the best possible care, by answering the following questions.

- Reason for today's visit _____
- Are you in good health? YES NO Height _____ Weight _____ Date of last physical exam _____
- Have there been any changes in your general health in the last year? YES NO
- Are you under the care of a physician for any condition? YES NO Date of last visit: _____
If yes, for what condition are you being treated? _____
- Have you been hospitalized or had any surgery in the past five years? YES NO Date of hospitalization: _____
Reason for hospitalization _____

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:

	Y	N	DOCTOR'S NOTES
rheumatic fever			
damaged heart valve or artificial heart valve			
mitral valve prolapse			
heart murmur			
high blood pressure			
low blood pressure			
chest pain or angina			
heart attack			
irregular heart beat			
cardiac pacemaker			
open heart surgery or angioplasty			
swollen ankles			
bronchitis / pneumonia			
chronic cough			
asthma			
hay fever / sinus problems			
tuberculosis			
emphysema			
shortness of breath			
any other lung trouble			
blood disorders such as anemia			
do you bruise easily?			
prolonged or heavy bleeding			
jaundice, hepatitis, liver disease			
stomach ulcers			
gallbladder trouble			

	Y	N	DOCTOR'S NOTES
fainting spells			
convulsions, seizures, epilepsy			
stroke			
thyroid trouble			
diabetes			
low blood sugar			
kidney trouble			
are you receiving dialysis?			
arthritis, joint trouble			
prosthetic (artificial) joint replacement			
contagious diseases			
sexually transmitted diseases			
AIDS or HIV infection			
have you had radiation or chemotherapy?			
blood transfusion			
cancer, tumor or other growth			
depression or other mental health problems			
removable dental appliances			
eye disease / glaucoma			
do you wear contact lenses?			
pain or clicking of the jaw joints (TMJ)			
malignant hyperthermia			
any reaction to anesthesia			
do you smoke?			
do you drink alcoholic beverages?			
do you use addictive drugs?			

- Have you ever taken prescription medication for weight reduction (diet pills)? YES NO
- Are you currently taking, or have you ever taken any of the following medications for the treatment of osteoporosis or cancer?

<input type="checkbox"/> Fosamax (alendronate)	<input type="checkbox"/> Actonel (risedronate)	<input type="checkbox"/> Boniva (ibandronate)	<input type="checkbox"/> Skelid (tiludronate)
<input type="checkbox"/> Didronel (etidronate)	<input type="checkbox"/> Aredia (pamidronate)	<input type="checkbox"/> Zometa (zoledronic acid)	<input type="checkbox"/> Other

NO

MEDICATIONS:

Are you currently taking any of the following medications?	Y	N
anticoagulants (blood thinners) including aspirin		
tranquilizers/sleeping pills		
cortisone		
other medications? (please list)		

ALLERGIES:

Are you allergic to, or have you ever had a reaction to any of the following?	Y	N
local anesthetics (novocain)		
penicillin or other antibiotics		
sulfa drugs		
barbiturates, sedatives, or sleeping pills		
aspirin		
codeine or other narcotics		
other medications? (please list)		

WOMEN: Is there ANY possibility you may be pregnant? YES NO Are you nursing? YES NO Do you take birth control pills? YES NO

IS THERE ANY OTHER CONDITION CONCERNING YOUR HEALTH OF WHICH THE DOCTOR SHOULD BE AWARE? YES NO

If yes, please explain _____

I hereby certify that I have read and understand the above. I acknowledge that my questions, if any, about the above health history questionnaire have been answered to my satisfaction. I will not hold my surgeon or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ **Reviewed** _____ **Date** _____

MH UPDATE _____ CHANGES _____

MH UPDATE _____ CHANGES _____

MH UPDATE _____ CHANGES _____

CONSENT TO TREATMENT AND ANESTHESIA ***please do not write in this section***

I hereby give Dr. Karras my consent to treat the following condition(s): _____

The procedures necessary to treat my condition have been explained to me as: _____

I understand that some possible complications of oral surgery include but may not be limited to:

- | | |
|--|--|
| 1. Pain, swelling, bruising | 7. Displacement of tooth roots into the sinus or creation of an opening into the sinus which may require additional treatment or surgery |
| 2. Prolonged or heavy bleeding that may require additional treatment | 8. The decision to leave a root or a portion of a root in place if its removal would require extensive surgery or involve excessive risk |
| 3. Infection that may require additional treatment | 9. Restricted mouth opening for several days after surgery, which may be related to muscle soreness or to stress on the jaw joints |
| 4. Damage to adjacent teeth or fillings | 10. Dry socket / delayed healing |
| 5. Stretching the corners of the mouth that may cause bruising | |
| 6. Injury to the nerve underlying the lower teeth that may result in temporary or permanent numbness of the lip, chin, teeth, gums or tongue | |

I also consent to the administration of _____ anesthesia in connection with the above procedures.

I understand that some possible complications of intravenous (I.V.) sedation and general anesthesia include but may not be limited to:

- | | |
|--|---|
| 1. Allergic reactions to the medications used in the procedure | 5. Sedation and general anesthesia are commonly given in office settings by Oral and Maxillofacial Surgeons and are considered safe. They are, however, serious medical procedures and carry with them the risks of brain damage, heart attack, or death. |
| 2. Discomfort, swelling or bruising at the I.V. site | |
| 3. Vein irritation (phlebitis) that may require additional treatment | |
| 4. Nausea and vomiting that may require bed rest or medications | |

All reasonable alternatives to the proposed treatment have been explained to my satisfaction, and I have been given no warranty or guarantee as to the results of treatment or a cure for my condition. I understand that certain medications that may be prescribed for me can cause drowsiness and decreased coordination and awareness that may be worsened by the use of alcohol or other drugs. I agree not to operate a motor vehicle or any hazardous machinery until I have fully recovered from the effects of these medications. I understand that such recovery may take up to 24 hours or longer. I certify that I speak, read, and write English and that I have read and fully understand this consent for oral surgery and anesthesia.

_____ Date: _____
 Patient (Parent/guardian if minor) _____ Witness _____