Welcome to our Practice

PATIENT INFORMATION: **Date:**_____

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑Male ❑Female Birth Date_____ Age_____ Soc.Sec.#_____

Street_____ Apt_____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____

Have you ever been a patient of our practice? ❑Yes ❑N Has a family member ever been a patient of our practice? ❑Yes ❑No

Referred By_____ _____ Dentist_____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Orthodontist_____ _____ Medical Dr._____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's License #_____ Nearest relative not living with you_____
NAME AND PHONE NUMBER

Employer_____ Business Phone (____)_____

Personal Payment Type: ❑Cash ❑Check ❑Credit Carc We accept: Visa, Mastercard, Discover and CareCredit

In case of emergency_____ _____ Phone_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑Self (If self, skip this section) ❑Spouse ❑Father ❑Mother ❑Other_____

Name_____ _____

Sex: ❑Male ❑Female Birth Date_____ Age_____ Soc.Sec.#_____

Street_____ Apt_____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell (____)_____

Driver's License #_____ Employer_____ Bus. Phone (____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: ***(IF DIFFERENT FROM ABOVE)***

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑Male ❑Female Birth Date_____ Age_____ Soc.Sec.#_____

Street_____ Apt_____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____

Employer_____ Business Phone (____)_____

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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
1.	***Height***_____ ***Weight***_____	❑	❑
2.	Have there been any changes in your general health in the past year?.....	❑	❑
3.	Are you under the care of a physician?..... ***Date of last visit?***_____	❑	❑
	If so, for what are you being treated?_____		
4.	Have you had any illness, operation or been hospitalized in the past five years?.....	❑	❑
	If so, describe_____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?.....	❑	❑
	If so, describe where_____		
6.	Do you have a prosthetic joint / implant?..... ***If so, describe where***_____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?.....	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?.....	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

	YES	NO	NOTES		YES	NO	NOTES
10. Rheumatic fever?	❑	❑		32. Bleeding tendency/abnormal bleeding?	❑	❑	
11. Damaged heart valves/mitral valve prolapse?	❑	❑		33. Hepatitis, jaundice, or liver disease?	❑	❑	
12. Heart murmur?	❑	❑		34. Infectious mononucleosis?	❑	❑	
13. High blood pressure?	❑	❑		35. Gallbladder trouble?	❑	❑	
14. Low blood pressure?	❑	❑		36. Fainting spells?	❑	❑	
15. Chest pain/angina?	❑	❑		37. Convulsions/epilepsy?	❑	❑	
16. Heart attack(s)?	❑	❑		38. Stroke?	❑	❑	
17. Irregular heart beat?	❑	❑		39. Thyroid trouble?	❑	❑	
18. Cardiac pacemaker?	❑	❑		40. Diabetes?	❑	❑	
19. Heart surgery?	❑	❑		41. Low blood sugar?	❑	❑	
20. Pneumonia, chronic cough, bronchitis?	❑	❑		42. Kidney trouble?	❑	❑	
21. Asthma?	❑	❑		43. High cholesterol?	❑	❑	
22. Hay fever/sinus problems?	❑	❑		44. On dialysis?	❑	❑	
23. Snoring/sleep apnea?	❑	❑		45. Swollen ankles/ arthritis/joint disease?	❑	❑	
24. Difficult breathing/other lung trouble?	❑	❑		46. Osteoporosis/osteopenia	❑	❑	
25. Tuberculosis?	❑	❑		47. Osteonecrosis?	❑	❑	
26. Emphysema?	❑	❑		48. Stomach ulcers/acid reflux?	❑	❑	
27. Do you smoke? packs per day_____	❑	❑		49. Contagious disease?	❑	❑	
28. Do you use chewing tobacco?	❑	❑		50. Sexually transmitted diseases?	❑	❑	
29. Blood transfusion?	❑	❑		51. Delay in healing?	❑	❑	
30. Blood disorder (eg. anemia)?	❑	❑		52. A tumor or growth?	❑	❑	
31. Bruise easily?	❑	❑		53. Chronic fatigue/night sweats?	❑	❑	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
54. Immune system problems?	❑	❑	
55. Are you on a diet?	❑	❑	
56.Cancer/radiation/ chemotherapy?	❑	❑	
57. History of alcohol abuse?	❑	❑	
58. History of drug abuse?	❑	❑	
59. Contact lenses?	❑	❑	
60. Eye disease/glaucoma?	❑	❑	
61. Mental health problems?	❑	❑	

WOMEN ONLY: (QUESTIONS 64-67)	YES	NO	NOTES
64. Is there a possibility of pregnancy?.....	❑	❑	
65. Expected delivery date?_____			
66. Are you nursing?	❑	❑	
67. Are you taking birth control pills?	❑	❑	

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth contol pills. Consult your physician/OBgyn for assistance regarding other methods of birth control.*

IS THERE A FAMILY HISTORY OF:		
68. Cancer?.....	❑Yes	❑No
69. Diabetes?.....	❑Yes	❑No
70. Heart disease?....	❑Yes	❑No
71. Anesthesia issues	❑Yes	❑No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
72. Local anesthetic?	❑	❑	
73. Penicillin?	❑	❑	
74. Other antibiotics?	❑	❑	
75. Sulfa drugs?	❑	❑	
76. Sodium pentothal/ valium/ other tranquilizers?	❑	❑	
77. Aspirin?	❑	❑	
78. Amoxicillin?	❑	❑	
79. Codeine or other narcotics?	❑	❑	
80. Other medications?	❑	❑	
81. Latex?	❑	❑	
82. Soy?	❑	❑	
83. Eggs/ yolk	❑	❑	
84. Sulfites?	❑	❑	
85. Any known allergies?	❑	❑	

86. Please list any allergies other than drug allergies:

ARE YOU NOW TAKING:	YES	NO	NOTES
87. Any kind of medication, drug, pills?	❑	❑	
Aspirin, Vitamin E, Ginko biloba, Aggrenox,	❑	❑	
89. Have you ever taken diet pills?	❑	❑	
or homeopathic remedy?	❑	❑	
91. Are you taking, or have you ever taken, bone density meds, or bisphosphonates	❑	❑	

92. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?
If so, please list:

93. Please list any medications you are currently taking:

MEDICATION	DOSAGE	FREQUENCY

If you are having surgery **today**, have you had anything to eat or drink in the last 6 hours? ❑Yes ❑No

Who is driving you home?_____

Is there any condition concerning your health that the Doctor should be told about? ❑Yes ❑No

If yes, please describe:_____

_____

Do you wish to speak to the doctor privately about anything? ❑Yes ❑No

Is this visit related to an accident? ❑Yes ❑No

If yes, what type of accident? ❑Automobile ❑Work related ❑Other

Date of injury_____

Insurance company handling the claim_____

Claim number_____

Name of attorney / adjustor_____

Telephone number (_____) _____

I certify that I have read and I understand the questions on this patient history form. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____
Signature of patient *(Parent or Guardian if Minor)*

X_____
Reviewed by

X_____
Date

FEES & PAYMENTS

We make every effort to keep down the cost of your 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 vertain 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, attorney fees and court costs.

X_____ **X**_____

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.

X_____ **X**_____

Signature of patient *(Parent or Guardian if Minor)* **Date**

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 to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X_____ **X**_____ **X**_____ **X**_____

Signature of patient *(Parent or Guardian if Minor)* **Witness** **Doctor** **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.

X_____ **X**_____

Signature of patient *(Parent or Guardian if Minor)* **Date**