WELCOME TO ORAL SURGERY CENTER

Please take a few minutes to answer the following questions so we can better assist you with your oral surgery needs.

Date _____ **PATIENT INFORMATION** Account No._____

First Name _____ Last Name _____

Sex: ☐ Male ☐ Female Birth Date _____Age _____ Social Security. # _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Have you ever been a patient of our practice? ☐ Yes ☐ No

Street _____ Apt # _____ City _____ State _____ Zip _____

Home # (_____) _____ Cell # (_____) _____E-mail _____

Dentist Name _____ Medical Doctor _____ Who should we thank for referring you? _____

Employer _____ Occupation _____Bus. Tel. (_____) _____

In case of Emergency, who should we contact? _____Relationship _____ Phone # (_____) _____

Method of Personal Payment: ☐ Cash ☐ Care Credit ☐ Check ☐ Credit Card

INSURANCE INFORMATION

Person Responsible for Account _____Last Name _____
Relationship to Patient _____Date of Birth_____Soc. Sec. # _____
Address _____ Apt# _____ Home Phone _____
City _____State_____Zip _____
Responsible Party Employed By _____Business Phone _____
Business Address _____Occupation _____

Insurance Company _____Address _____
Subscriber I.D. # _____Group # _____

ADDITIONAL INSURANCE INFORMATION

Insured Name _____Last Name _____
Relationship to Patient _____Date of Birth_____Soc. Sec. # _____
Address _____Home Phone _____
City _____State _____Zip Code _____

Insured Employed By _____Business Phone _____
Insurance Company _____Address _____
Subscriber I.D. # _____Group # _____

HEALTH HISTORY

To our patients: Correct answers to the following questions are extremely important to enable your doctor to treat you on a more individual basis, and to provide care appropriate to your needs. Be assured that strict confidentiality of your health and treatment record will be maintained at all times, and treatment will not be denied to you based on your honest answers. If you are uncertain or uncomfortable answering any of these questions, you may discuss your concerns privately with your doctor.

Reason for today's office visit

Whom may we thank for referring you?

FIRST NAME LAST NAME

		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?	❑	❑
	If so, describe		
103.	Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where		
104.	Do you have a artificial 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	Congenital heart disease?			
110	High blood pressure?			
111	Low blood pressure?			
112	Chest pain / angina?			
113	Heart attack(s)?			
114	Irregular heart beat?			
115	Cardiac pacemaker?			
116	Heart surgery artificial valve / stent / etc.?			
117	Shortness of breath?			
118	Pneumonia / bronchitis / chronic cough / emphysema?			
119	Cough up bloody sputum or blood?			
120	Asthma?			
121	Hay fever / sinus problems / nose bleeds?			
122	Snoring / sleep apnea?			
123	Tuberculosis or other lung trouble?			
124	Do you smoke?			
125	Do you use chewing tobacco?			
126	Blood transfusion?			
127	Blood disorder such as anemia?			
128	Bruise easily or hemophilia?			
129	Any recent skin changes / disease?			
130	Bleeding tendency / abnormal bleeding during previous extractions?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
131	Hepatitis, jaundice, or liver disease?			
132	Infectious mononucleosis?			
133	Fainting spells?			
134	Headaches / migraines?			
135	Convulsions / epilepsy?			
136	Stroke?			
137	Thyroid trouble / goiter?			
138	Diabetes?			
139	Low blood sugar?			
140	Kidney trouble?			
141	Are you on dialysis?			
142	Osteoporosis / Osteopenia?			
143	Arthritis / rheumatism?			
144	Are you, or have you ever been, at risk for contraction of the following communicable diseases: HIV/AIDS or Herpes?			
145	Are you immunosuppressed? Possibly from transplant surgery, etc.			
146	Persistent fever?			
147	Delay in healing?			
148	A tumor or growth?			
149	Cancer / radiation therapy / chemotherapy?			
150	Are you on a diet, or have had any marked weight change?			
151	Chronic fatigue / night sweats?			
152	Do you drink more than 2 alcoholic beverages per day?			
153	Psychiatric treatment (Depression, Anxiety, Bipolar, etc.)?			
154	Eye disease / glaucoma?			

Please Note: All numbering is not sequential.

MEDICATION – Are you now taking or have you taken. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
206	Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:			
207	Please list any medications you are currently taking:			

ALLERGIES – Are you allergic to, or had a reaction to. . .

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

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 (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

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.*

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

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.

X **Date** X **Signature of patient** *(Parent or Guardian if minor)*

Witness: X

Doctor: 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

Print Form **Submit Form**