WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

Today's Date _____

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

Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Sex Assigned at Birth: ❑ F ❑ M ❑ Other _____ Current Gender Identity: ❑ F ❑ M ❑ Non-Binary ❑ Other _____

Personal Pronouns (select all that apply): ❑ She / Her / Hers ❑ He / Him / His ❑ They / Them / Their ❑ Other _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(_____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

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

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

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

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____

Gender listed on insurance plan: ❑ Male ❑ Female ❑ Other _____

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

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____

Gender listed on insurance plan: ❑ Male ❑ Female ❑ Other _____

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

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____

Gender listed on insurance plan: ❑ Male ❑ Female ❑ Other _____

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

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____

Gender listed on insurance plan: ❑ Male ❑ Female ❑ Other _____

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

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Patient Name _____

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*** _____ Are you in good health?	❑	❑
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 ever had general anesthesia or IV sedation?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day _____			
30. Do you use chewing tobacco?			
31. Alcohol intake? If so, drinks per Day _____ Week _____			
32. Blood transfusion?			
33. Blood disorder such as anemia?			
34. Bruise easily?			
35. Bleeding tendency / abnormal bleed?			
36. Hepatitis, jaundice, or liver disease?			
37. Infectious mononucleosis?			
38. Gallbladder trouble?			
39. Fainting spells?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
40. Convulsions / epilepsy?			
41. Stroke?			
42. Thyroid trouble?			
43. Diabetes?			
44. Low blood sugar?			
45. Kidney trouble?			
46. High cholesterol?			
47. Are you on dialysis?			
48. Swollen ankles / arthritis / joint disease?			
49. Osteoporosis / osteopenia?			
50. Osteonecrosis?			
51. Stomach ulcer / acid reflux?			
52. COVID–19?			
53. Contagious diseases?			
54. Sexually transmitted diseases?			
55. Problems with immune system? Possibly from medication / surgery, etc.			
56. Autoimmune disease?			
57. Delay in healing?			
58. A tumor or growth?			
59. Cancer / radiation therapy / chemotherapy?			
60. Chronic fatigue / night sweats?			
61. Are you on a diet?			
62. Is there a history / treatment for an alcohol use disorder?			
63. Is there a history / treatment for a marijuana or substance use disorder?			
64. Contact lenses?			
65. Eye disease / glaucoma?			
66. Mental health problems / anxiety / depression?			
67. A removable dental appliance?			
68. Pain or clicking of jaws when eating?			

Patient Name _____

WOMEN ONLY: *(QUESTIONS 69–72)*

	Yes	No
69. Is there a possibility of pregnancy?	❑	❑
70. Expected delivery date? _____		
71. Are you nursing?	❑	❑
72. Are you taking birth control pills?	❑	❑

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

ARE YOU NOW TAKING:	YES	NO	NOTES
73. Any kind of medication, drug, pills?			
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
75. Have you ever taken diet pills?			
76. Any natural product, herbal supplement or homeopathic remedy?			
77. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

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

79. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other _____

Treating doctor: _____

80. Please list any medications you are currently taking:

Medication	Dosage	Frequency

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

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

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
81. Local anesthetic (numbing meds.)?			
82. Penicillin?			
83. Other antibiotics?			
84. Sulfa drugs?			
85. Sodium pentothal / Valium /other tranquilizers?			
86. Aspirin?			
87. Amoxicillin?			
88. Codeine or other narcotics?			
89. Latex?			
90. Soy?			
91. Eggs / yolk?			
92. Sulfites?			
93. Do you have any known allergies?			

94. Please list any allergies other than drug allergies:

95. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

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 (_____) _____

Patient Name _____

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 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 _____ **X** _____ **X** _____ **X** _____

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

POLICY FOR APPOINTMENTS INVOLVING SURGERY

The day of your appointment, if you are having surgery, there may be driving and / or eating restrictions. The office will review this information with you prior to your procedure. I acknowledge that I have read and I understand the policy above.

X _____ **X** _____

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

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 and / or mobile phone concerning my appointment

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **X** _____ **X** _____

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