

Welcome to our Practice

Today's Date _____

PATIENT INFORMATION:

First Name _____ M.I. _____ Last Name _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? Yes No
Referred By _____ Has a family member ever been a patient of our practice? Yes No
Dentist FIRST NAME _____ LAST NAME _____ Orthodontist FIRST NAME _____ LAST NAME _____
Preferred Pharmacy _____ Tel.(_____) _____
Driver's Lic.# _____ Nearest relative not living with you FIRST NAME _____ LAST NAME _____ Tel.(_____) _____
Employer _____ Bus. Tel.(_____) _____
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
Marital Status: . Married Divorced Widow Single Legally Separated
Employed: Full Time Part Time Retired Not

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 _____ Sex: M F
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 _____ Sex: M F
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 _____ Sex: M F
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 _____ Sex: M F
S.S. # _____ Tel.(_____) _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? Date of last visit _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, for what are you being treated? _____ | | |
| 4. Have you had any illness, operation or been hospitalized in the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe _____ | | |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, describe where _____ | | |
| 6. Do you have a prosthetic joint / implant? If so, describe where _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia or IV sedation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |

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 _____

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.**

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

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