Dr. _____

Acct. # _____

Welcome To Our Practice

Date: _____

Patient: (Mr., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Sex: ☐ Male ☐ Female Date of Birth _____ Age _____ Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (___) _____ Cell # _____ Business Tel. #(___) _____

Dentist _____ Physician _____ Ph# _____ Referred By _____

Emergency Contact _____ Tel. # (___) _____ E-mail Address _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Method of Personal Payment: ☐ Cash ☐ Check ☐ Credit Card

Responsible Party: Who will be responsible for your acct. ☐ self ☐ spouse ☐ parent ☐ other

Name _____ Soc. Sec. # _____ Home Tel. # (___) _____

Street _____ City _____ State _____ Zip _____

Date of Birth _____ Employer _____ Bus. Tel. # (___) _____

INSURANCE INFORMATION

Patient: Student: Full Time ☐ Part Time ☐ Not ☐ School Name/ Address _____

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐ _____

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

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Tel. # _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Phone # (____) _____

Group # _____ Group Name _____

Insured party _____ Relation _____

Sex: ☐ M ☐ F _____ Date of Birth _____

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Tel. # _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Phone # (____) _____

Group # _____ Group Name _____

Insured party _____ Relation _____

Sex: ☐ M ☐ F _____ Date of Birth _____

I.D. # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Tel. # _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Phone # (___) _____

Group # _____ Group Name _____

Insured party _____ Relation _____

Sex: ☐ M ☐ F _____ Date of Birth _____

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Tel. # _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Phone # (___) _____

Group # _____ Group Name _____

Insured party _____ Relation _____

Sex: ☐ M ☐ F _____ Date of Birth _____

I.D. # _____

OFFICE POLICY

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 of 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.

Promissory Note

The undersigned patient and/or guarantor promise to pay all charges incurred whether covered by insurance or not. If this account should become delinquent, I further agree to pay all late payment costs (1 1/2% per month), court costs, suit fees, legal fees and collection costs caused by my not paying my bill within 30 days. Should I not meet the exact specifications of this payment arrangement the above listed costs would be my responsibility as I created the delinquent account problem.

Failure to cancel reserved surgical time within 2 business days will result in a $250.00 missed appointment charge.

_____ _____

Patient or Guarantor Name (Print) Patient or Guarantor Signature

Witness _____ Date _____

- HEALTH HISTORY -

To our patients:
Although oral and maxillofacial surgeons primarily treat the area in and around your mouth and face, they are parts of your entire body. Health problems that you may have or medication 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
100.	Are you in good health? ..... Height _____ Weight _____	❑	❑
101.	Have there been any changes in your general health in the past year?	❑	❑
102.	Are you under the care of a physician? ..... Date of last visit: _____	❑	❑
	If so, for what are you being treated? _____		
	_____		
103.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
104.	Do you have unhealed injuries or inflamed areas in or around your mouth, growth or sore spots in your mouth? ..... If so, describe where _____	❑	❑
105.	Do you have a prosthetic joint? ..... If so, describe where _____	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
106	Rheumatic fever?				132	Stroke?			
107	Damaged heart valves/ mitral valve prolapse?				133	Thyroid trouble?			
108	Heart murmur?				134	Diabetes?			
109	High blood pressure?				135	Low blood sugar?			
110	Low blood pressure?				136	Kidney trouble?			
111	Chest pain, angina?				137	Are you on dialysis?			
112	Heart attack(s)?				138	Swollen ankles, arthritis or joint disease?			
113	Irregular heart beat?				139	Stomach ulcers?			
114	Cardiac pacemaker?				140	Contagious diseases?			
115	Heart surgery?				141	Sexually transmitted diseases?			
116	Bronchitis, chronic cough?				142	Do you have any reason to be immunosuppressed?			
117	Asthma?				143	Delay in healing?			
118	Hayfever/Sinus problems?				144	A tumor or growth?			
119	Tuberculosis?				145	Radiotherapy/Chemotherapy			
120	Emphysema?				146	Chronic fatigue/night sweats?			
121	Sleep apnea disorder?				147	Are you on a diet?			
122	Do you smoke or chew tobacco?				148	High Cholesterol?			
123	Blood transfusion				149	A history of alcohol / drug abuse?			
124	Blood disorder such as anemia?				150	Contact lenses?			
125	Bruise easily?				151	Eye disease / glaucoma?			
126	Bleeding tendency (abnormal bleed)?				152	Mental health problems?			
127	Jaundice, hepatitis or liver disease?				153	A removable dental appliance?			
128	Infectious mononucleosis?				154	Pain & clicking of jaws when eating?			
129	Gallbladder trouble?				155	Malignant Hyperthermia?			
130	Fainting spells?				156	Have you had anything to eat or drink in the last 8 hours?			
131	Convulsions, epilepsy?				157	Who is driving you home today?			

Patient's Name: _____

MEDICATIONS

	YES	NO
PHARMACY NAME _____ PHONE # _____		
201. **ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?**	❑	❑
202. Anticoagulants?	❑	❑
203. Tranquilizers?	❑	❑
204. Cortisone?	❑	❑
205. Have ever or currently taken bisphoshonates?	❑	❑
206. Other medications? (Please list) _____		

ALLERGIES

	YES	NO
207. **ARE YOU ALLERGIC TO OR HAD A REACTION TO LOCAL OR GENERAL ANESTHETICS?**	❑	❑
208. Penicillin?	❑	❑
209. Other antibiotics?	❑	❑
210. Sulfa Drugs?	❑	❑
211. Sodium pentothal, Valium, or other tranquilizers?	❑	❑
212. Aspirin?	❑	❑
213. Codeine or other narcotics?	❑	❑
214. Other medications?	❑	❑
215. Allergies other than drug allergies? (Please list) _____	❑	❑

WOMEN:

216. Is there a possibility that you may be pregnant?	❑	❑
217. Estimated delivery date? _____		
218. Are you nursing?	❑	❑
219. Are you taking birth control pills?	❑	❑

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.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? 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 ❑

I certify that I have read and 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: _____ Date: _____ Reviewed by: _____
(Parent or Guardian if minor)

We will attempt to contact your insurer to determine any co-payment, deductible or co-insurance. Any misinformation communicated to us by your insurer is ultimately the patient's responsibility, as this is a contract between the insured and their insurance company. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the benefits otherwise payable to me.

Signature _____ Date _____

NOTES

Patient's Name: _____