# Welcome to our Practice

**PATIENT INFORMATION:** Today's Date _____

First Name _____ M.I.____ Last Name_____

Sex: □ Male □ Female Birth Date _____ Age _____ Soc. Sec. #_____

Mailing Address_____ 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 _____ Orthodontist _____ Medical Dr. _____

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

Nearest relative not living with you _____ Tel. ( ____ ) _____

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

Email Address _____

**WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:**

□ Self (**if self, skip this section**) □ Spouse □ Father □ Mother □ Other _____

Name _____ S.S. # _____ Birth Date _____ Age _____

Tel. ( ____ ) _____ Cell. ( ____ ) _____ Employer _____ Bus. Tel. ( ____ ) _____

Street _____ Apt. _____ City _____ State _____ Zip_____

**INSURANCE:**

Primary Subscriber Name _____ Birth Date _____ Soc. Sec. # _____

Secondary Subscriber Name _____ Birth Date _____ Soc. Sec. # _____

**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. Are you under the care of a physician?..... | □ | □ |
| ***If so, for what are you being treated?*** _____ | | |
| 3. Have you had any illness, operation or been hospitalized in the past five years? ..... | □ | □ |
| ***If so, please describe*** _____ | | |
| 4. Do you have a prosthetic joint / implant? .....***If so, describe where*** _____ | □ | □ |
| 5. Have you had a heart valve replacement or vascular graft?..... | □ | □ |
| 6. Have you ever had general anesthesia?..... | □ | □ |
| 7. Have you, or a family member, had any unusual or serious reactions to general anesthesia? ..... | □ | □ |
| 8. Is there a family history of heart disease?..... | □ | □ |
| 9. Is there a family history of anesthesia problems?..... | □ | □ |
| ***Women Only:*** | | |
| 10. Are you pregnant or a chance you could be pregnant? ..... | □ | □ |
| 11. Expected delivery date? _____ | | |
| 12. Are you nursing? ..... | □ | □ |

## MEDICATIONS:

***ARE YOU CURRENTLY TAKING:*** **YES** **NO**

1. Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E., Ginkgo biloba, Aggrenox, Pradaxa, Fish oil)?..... ☐ ☐
2. Are you taking, or have you ever taken bone density meds: RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 months?.. ☐ ☐
3. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?..... ☐ ☐

***4. Please list any medications you are currently taking:***

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
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| | | |
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| | | |
| | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 1. Rheumatic fever? | | | |
| 2. Damaged heart valves / mitral valve prolapse? | | | |
| 3. Heart murmur? | | | |
| 4. High blood pressure? | | | |
| 5. Low blood pressure? | | | |
| 6. Chest pain / angina? | | | |
| 7. Heart attack(s)? | | | |
| 8. Irregular heart beat? | | | |
| 9. Cardiac pacemaker? | | | |
| 10. Heart surgery? | | | |
| 11. Chronic Cough? | | | |
| 12. Asthma? | | | |
| 13. Snoring? | | | |
| 14. Sleep apnea / CPAP? | | | |
| 15. Difficult breathing / other lung trouble? | | | |
| 16. Tuberculosis? | | | |
| 17. Jaw Joint Problems? | | | |
| 18. Mental health problems / anxiety / depression? | | | |
| 19. Do you smoke? If so, number of packs a day _____ | | | |
| 20. Emphysema (COPD)? | | | |
| 21. Do you use chewing tobacco? | | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: | YES | NO | NOTES |
|---|---|---|---|
| 22. Liver disease? | | | |
| 23. Problems with immune system? Possibly from medication/surgery, etc | | | |
| 24. Bleeding tendency / abnormal bleeding? | | | |
| 25. Hepatitis / HIV? | | | |
| 26. Convulsions / epilepsy? | | | |
| 27. Stroke? | | | |
| 28. Thyroid trouble? | | | |
| 29. Diabetes? | | | |
| 30. Kidney trouble? | | | |
| 31. Blood disorder such as anemia? | | | |
| 32. Are you on dialysis? | | | |
| 33. Swollen ankles / Arthritis / joint disease? | | | |
| 34. Osteoporosis / osteopenia? | | | |
| 35. Stomach ulcers / acid reflux? | | | |
| 36. Cerebral Palsy / Muscular Dystrophy? | | | |
| 37. Delay in healing? | | | |
| 38. A tumor or growth? | | | |
| 39. Cancer / Radiation Therapy / Chemotherapy? | | | |
| 40. A history of drug abuse? | | | |
| 41. A history of alcohol abuse? | | | |
| 42. Eye disease / glaucoma? | | | |

**ALLERGIES**

**Do you have any known allergies? ☐ YES or ☐ NO Please list:**

Patient Name _____ Today's 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. 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 insurance, we will be glad to call for your benefits.

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. **Full payment for professional services is YOUR responsibility, regardless of the amount paid under your policy.** I understand and acknowledge that I am legally responsible for all charges incurred on my account as well as any attorney fees or collection agency fees associated with collecting the account balance.

## AUTHORIZATION:

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination, for the purposes 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.

***Please Initial:***

_____ I consent to the taking of clinical photographs used for educational purposes. I understand my identity will be unknown.

No cell phone use (calls, photos, videotaping/recording) allowed in consultation or treatment rooms. This is due to the HIPAA confidentiality regulations. Thank you for your cooperation and respect for our patients and employee's privacy.

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.

**If you would like us to release your information to someone who may call on your behalf, please list their name(s) below:**

1. Name: _____
   Phone Number: _____
   Relationship to Patient: _____

2. Name: _____
   Phone Number:_____
   Relationship to Patient:_____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**I certify** that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth 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 _____
Signature of patient (Parent or Guardian if Minor) Date