Welcome to our Practice

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

Patient Name (First, MI, Last) _____

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

Mailing Address_____ City _____ State _____ Zip_____

Home # (____) _____Cell # (_____) _____ Email _____

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

Employer _____ Bus.Tel. (_____) _____

Referred By _____

Medical Dr. _____

Pharmacy Name _____ Pharmacy City/Sate/Zip _____

Preferred Pathology Lab: ☐ Mercy Southeast Lab ☐ St. Francis Lab ☐ Labcorp

ACCOUNT RESPONSIBILITY:

- **Age 18+ with NO Power of Attorney, Select: ☐ SELF (IF SELF, skip this section)**
- **IF MINOR OR have a Power of Attorney, select:** ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name _____ S.S. # _____ Birth Date _____

Home Address _____ City _____ State _____ Zip_____

Home # (____) _____Cell # (____) _____ Employer _____ Bus. Tel. (____) _____

DENTAL INSURANCE:

Primary Dental: _____

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

Secondary Dental: _____

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

HEALTH HISTORY:

Reason for today's office visit? _____

Height _____ **Weight** _____

1. ***Please list previous surgeries:*** _____

   _____

   _____

   _____

2. Have you, or a family member, had any unusual or serious reactions to general anesthesia? YES / NO

MEDICATIONS:

1. **Please list any medications you are currently taking:**
   - ***If you do not take any medications at this time, please write "NONE"***

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ALLERGIES

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

***Women Only*:**

	YES	NO
1. Are you pregnant or a chance you could be pregnant?	☐	☐
2. Expected delivery date? _____		
3. Are you nursing?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
1. Damaged heart valves?			
2. Heart murmur?			
3. High blood pressure?			
4. Chest pain / angina?			
5. Heart attack(s)?			
6. Irregular heart beat?			
7. Cardiac pacemaker?			
8. Heart surgery?			
9. Chronic Cough?			
10. Asthma?			
11. Sleep apnea / CPAP?			
12. Difficult breathing / other lung trouble?			
13. Do you smoke? If so, number of packs a day _____			
14. A history of drug or alcohol abuse?			
15. Do you use chewing tobacco?			
16. Do you use marijuana?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
17. Liver disease?			
18. Bleeding tendency / abnormal bleeding?			
19. Hepatitis / HIV?			
20. Seizures?			
21. Stroke?			
22. Thyroid problem?			
23. Diabetes?			
24. Kidney problem?			
25. Blood disorder such as anemia?			
26. Are you on dialysis?			
27. Osteoporosis / osteopenia?			
28. Cerebral Palsy / Muscular Dystrophy?			
29. Cancer / Radiation Therapy / Chemotherapy?			
30. Problems with immune system? Possibly from medication/surgery, etc			
31. Anxiety / depression?			
32. Jaw Joint Problems (TMJ)?			

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.

HIPAA:

To release your information to someone who may call on your behalf or drive you to your surgery appointment, 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