WELCOME TO OUR PRACTICE

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

Patient's First Name:_____ MI _____ Last_____

Nick Name:_____ Sex: Male ❑ Female ❑ Date of Birth_____/_____/_____ Age_____

SSN:_____/_____/_____ *The SSN is needed if there is no ID number on your insurance card.

Mailing Address_____ City_____ State_____ Zip_____

Street Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Cell (____)_____ Work (____)_____

Who may we thank for referring you?_____

Dentist_____ Orthodontist_____ Medical Doctor_____

Student: Full Time❑ Part Time ❑ Name of School _____

In case of emergency, please contact _____ Relation _____

Home Phone (____)_____ Cell (____)_____ Work (____)_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

For Office Use Only: We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because: _____ Signature:_____ Date:_____

PERSON RESPONSIBLE FOR YOUR ACCOUNT Self ? Yes ❑ (If YES, Skip this section.
No ❑ **If NO, this section must be completed.)**

First Name:_____ MI _____ Last_____

Date of Birth_____/_____/_____ SSN_____/_____/_____ *The SSN is needed if there is no ID number on your insurance card.

Mailing Address_____ City_____ State_____ Zip_____

Street Address_____ City_____ State_____ Zip_____

Home # (____)_____ Cell (____)_____ Work (____)_____

FEES AND PAYMENTS: Fees are due at the time of service. 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 by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs should any be incurred.

THIS SECTION MUST BE SIGNED BY THE PATIENT OR THE PERSON FINANCIALLY RESPONSIBLE (if under 18).

X_____ **X**_____
Signature of patient or responsible party (Parent or Guardian if Minor) Date

Patient's Name_____ **Date of Birth**_____/_____/_____ **Date**_____

HEALTH HISTORY:

To Our Patients: *Although our surgeons primarily treat the area in and around your mouth, your mouth is a part of you of you 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 your visit today?_____

	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? Yes ❑ No ❑ 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? Yes ❑ No ❑ If so, describe where_____		
7. Have you, or a family member, had any unusual or serious reactions to general anesthesia?.....	❑	❑
8. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

	Yes	No		Yes	No
9. Rheumatic Fever			36. Fainting spells?		
10. Damaged heart valves/mitral valve prolapse?			37. Convulsions/epilepsy?		
11. Heart murmur?			38. Stroke?		
12. High blood pressure?			39. Thyroid trouble?		
13. Low blood pressure?			40. Diabetes?		
14. Chest pain/angina?			41. Low blood sugar?		
15. Heart attacks?			42. Kidney trouble?		
16. Irregular heart beat?			43. High cholesterol?		
17. Cardiac pacemaker?			44. Are you on dialysis?		
18. Heart surgery?			45. Swollen ankles/arthritis/joint disease?		
19. Pneumonia, bronchitis, chronic cough?			46. Osteoporosis/osteopenia?		
20. Asthma?			47. Osteonecrosis?		
21. Hay fever/sinus problems?			48. Stomach ulcers/acid reflux?		
22. Snoring/sleep apnea?			49. Contagious diseases?		
23. Difficult breathing/other lung trouble?			50. Sexually transmitted diseases?		
24. Tuberculosis?			51. Problems with immune system? Possibly from medication/surgery, etc.		
25. Emphysema?			52. Delay in healing?		
26. Do you smoke? If so, number of packs a day_____			53. A tumor or growth?		
27. Do you use chewing tobacco?			54. Cancer/radiation therapy/chemotherapy?		
28. A history of alcohol abuse?			55. Chronic fatigue/night sweats?		
29. Do you currently use or have ever used recreational/street drugs?			56. Are you on a diet?		
30. Blood transfusion?			57. Contact lenses?		
31. Blood disorder such as anemia?			58. Eye disease/glaucoma?		
32. Bruise easily?			59. Mental health problems/anxiety/depression?		
33. Bleeding tendency/abnormal bleed?			60. A removable dental appliance?		
34. Hepatitis, jaundice, or liver disease?			61. Pain or clicking of jaws when eating?		
35. Infectious mononucleosis?					

IF Y**OU ANSWERED YES TO ANY OF THE QUESTIONS ABOVE, PLEASE EXPLAIN:** _____

_____

_____

_____

Patient's Name_____ **Date of Birth**_____/_____/_____ **Date**_____

WOMEN ONLY: (QUESTIONS 62-64)

	Yes	No
62. Is there a possibility of pregnancy?..... Expected delivery date?_____/_____/_____	❑	❑
63. Are you nursing?.....	❑	❑
64. 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.

IS THERE A FAMILY HISTORY OF:

	Yes	No		Yes	No
65. Cancer?.....	❑	❑	67. Heart disease?.....	❑	❑
66. Diabetes?.....	❑	❑	68. Anesthesia problems?.....	❑	❑

ARE YOU NOW TAKING:

	Yes	No		Yes	No
69. Any kind of medication, drug, pills?.....	❑	❑	72. Any natural product, herbal supplement or homeopathic remedy?.....	❑	❑
70. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa Fish oil?.....	❑	❑	73. Are you taking, or have you ever taken, bone density meds, or bisphophonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia in the past 12 years?.....	❑	❑
71. Have you ever taken diet pills?.....	❑	❑	74. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please. please list:_____ _____	❑	❑

75. PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:

	Yes	No		Yes	No
76. Local anesthetic (numbing meds)?.....	❑	❑	83. Codeine or other narcotics?.....	❑	❑
77. Penicillin?.....	❑	❑	84. Other medications?.....	❑	❑
78. Other antibiotics?.....	❑	❑	85. Latex?.....	❑	❑
79. Sulfa drugs?.....	❑	❑	87. Soy?.....	❑	❑
80. Sodium pentothal/Valium/other tranquilizers?.....	❑	❑	88. Eggs/yolk?.....	❑	❑
81. Aspirin?.....	❑	❑	89. Sulfites?.....	❑	❑
82. Amoxicillin?.....	❑	❑	Please list any other drug or non-drug allergies you may have: _____ _____		

	Yes	No		Yes	No
Are there any conditions concerning your health that the Doctor should be told about? If Yes,describe___ _____ _____	❑	❑	Is this visit related to an accident?..... If Yes, what type of accident? Automobile ❑ Work related ❑ Other ❑ Date of injury_____/_____/_____	❑	❑
Do you wish to speak to the Doctor privately about anything?.....	❑	❑			

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.

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.

X_____ **X**_____
Signature of patient (Parent or Guardian if Minor) Date

X_____ **X**_____ **X**_____
Reviewed by/Witness Doctor Date

INSURANCE INFORMATION

Patient's Name_____ Date of Birth_____/_____/_____ Date_____

AUTHORIZATION

This signature on file is my authorization for the release of information necessary to process claim(s). I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ X_____

Signature of Patient OR Parent/Guardian if Minor Date

***** IF YOU ARE CONSIDERED A DEPENDANT ON THE INSURANCE POLICY, THE FOLLOWING INFORMATION MUST BE COMPLETED.***

PRIMARY DENTAL INSURANCE

Insured Party's First Name_____ MI _____ Last Name _____

Relation _____ Date of Birth_____/_____/_____ SSN_____/_____/_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Employer_____ Address_____

Insurance Company_____ ID#_____ Group#_____

Phone(____)_____Address_____ City_____State_____Zip_____

SECONDARY DENTAL INSURANCE

Insured Party's First Name_____ MI _____ Last Name _____

Relation _____ Date of Birth_____/_____/_____ SSN_____/_____/_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Employer_____ Address_____

Insurance Company_____ ID#_____ Group#_____

Phone(____)_____Address_____ City_____State_____Zip_____

PRIMARY MEDICAL INSURANCE

Insured Party's First Name_____ MI _____ Last Name _____

Relation _____ Date of Birth_____/_____/_____ SSN_____/_____/_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Employer_____ Address_____

Insurance Company_____ ID#_____ Group#_____

Phone(____)_____Address_____ City_____State_____Zip_____

SECONDARY MEDICAL INSURANCE

Insured Party's First Name_____ MI _____ Last Name _____

Relation _____ Date of Birth_____/_____/_____ SSN_____/_____/_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____ Cell (_____)_____ Work (_____)_____

Employer_____ Address_____

Insurance Company_____ ID#_____ Group#_____

Phone(____)_____Address_____ City_____State_____Zip_____