WELCOME

Thank you for selecting our oral surgical team! We strive to provide you with the best possible care. To help us meet all your surgical health care needs, please fill out this form completely. If you need any assistance or have any questions, please ask our friendly staff – we will be happy to help.

PATIENT INFORMATION *Email (to confirm appts):* _____

First Name _____ Last Name _____ Middle Initial ____ Phone _____

Social Security Number _____ Male Female Cell Phone _____

Minor Single Married Widowed **Birth Date** _____ Age _____

Address _____ City, State, Zip _____

Employer _____ Occupation _____ Work Phone _____

In event of an emergency, whom should we contact? Name _____ Relationship ____ Phone _____

(PARENT/ LEGAL GUARDIAN ACCOMPANYING MINOR)

First Name _____ Last Name _____ Relationship to Patient _____

Birth Date _____ Social Security Number _____ Home Phone _____

Address _____ City, State, Zip _____

Employer _____ Work Phone _____ Cell Phone _____

(THE FOLLOWING INFORMATION IS REQUIRED TO BILL YOUR INSURANCE)

PRIMARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Address _____
(if different from Patient)

Insured's Birth Date _____ Employer _____

Social Security # _____

Insurance Company _____

Insurance Address _____

Group # _____ ID# _____

SECONDARY INSURANCE

Name of Insured _____

Relationship to Patient _____

Address _____
(if different from Patient)

Insured's Birth Date _____ Employer _____

Social Security # _____

Insurance Company _____

Insurance Address _____

Group # _____ ID# _____

With the exception of your insurance and treating physicians, HIPAA restricts us from disclosing information to ANYONE without your written consent. If you wish to authorize release of information to someone (parent, spouse, friend etc...) please let us know:

_____ Name _____ Relationship

_____ Name _____ Relationship

I authorize and request my insurance company to pay directly to the dentist otherwise payable by me. I understand that my dental insurance carrier may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. You have my permission to contact me via cell phone to discuss any matters related to my account or that of my dependents.

Signature of patient or responsible party **X** _____ Date _____

Patient's Name_____ Age _____ Date _____

Medical Information

1. Have you been a patient in the hospital during the past year?..... Yes No
2. In the past two (2) years, have you had a serious illness requiring a physician's care? ..... Yes No

Physician's Name_____ **Dentist's Name** _____

3. List medications/drugs you are taking: _____

_____

4. List prior operations/hospitalizations:_____

_____

5. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Stroke	Yes	No	Psychiatric Problems	Yes	No	Hepatitis	A	B	C	D	No
Heart Disease or Attack	Yes	No	Ulcers	Yes	No	Liver Disease	Yes	No			
Angina Chest Pain	Yes	No	Diabetes	Yes	No	H.I.V. Positive/A.I.D.S	Yes	No			
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No			
High/Low Blood Pressure	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No			
Mitral Valve Prolapse	Yes	No	Cancer	Yes	No	Blood Transfusion	Yes	No			
Heart Pacemaker	Yes	No	Chemotherapy	Yes	No	Hemophilia	Yes	No			
Heart Surgery	Yes	No	Radiation Therapy	Yes	No	Anemia	Yes	No			
Rheumatic Fever	Yes	No	Lyme Disease	Yes	No	Sickle Cell Disease	Yes	No			
Artificial Heart Valve	Yes	No	Emphysema	Yes	No	Bruise Easily	Yes	No			
Artificial Joints (hip, knee, etc.)	Yes	No	Tuberculosis	Yes	No	Epilepsy or Seizures	Yes	No			
TMJ (jawjoint) problems	Yes	No	Asthma	Yes	No	Fainting or Dizzy Spells	Yes	No			
Snoring/Sleep Apnea	Yes	No	Allergies or Hives	Yes	No	Drug Addiction	Yes	No			
Severe/Frequent headaches	Yes	No	Sinus Problems	Yes	No						

6 Have you ever taken prescription medication for osteoporosis (bisphosphonate: fosamax, zoireta, areta)? Yes No

8. Are you sensitive or allergic to any of the following medications?

Penicillin	Yes	No	Codeine	Yes	No	Latex	Yes	No
Erythromycin	Yes	No	Aspirin/Ibuprofen	Yes	No	Local Anesthetics	Yes	No
Tetracycline	Yes	No	Tylenol/Acetaminophen	Yes	No			
Sulfa	Yes	No	Steroids	Yes	No	Other_____		

9. Do you smoke?..... Yes No How much per day_____
10. Do you drink alcohol?..... Yes No How much per day_____
10a. Do you take recreational drugs?..... Yes No
11. Do you have or have you had any disease, condition or problem not listed?..... Yes No

If yes, please list: _____

FOR WOMEN ONLY: Are you taking birth control pills? Yes No Are you nursing? Yes No
Are you pregnant? Yes No If yes, what month? _____

I understand the above information is necessary to provide safe surgical treatment. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature *(or Parent if minor)*_____ **Date** _____