Welcome To Our Practice

Date: _____

1.IP

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

Sex: ❑ Male ❑ Female Date of Birth _____ Age ____ Soc. Sec.# _____ Email (optional) _____

Street _____ City _____ State _____ Zip _____

Home Tel.# (____) _____ Business Tel. # (____) _____ Ext. _____ Employer _____

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic. # _____ Nearest relative not living with you _____ Tel. # (____) _____

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

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____
(If self, skip to next paragraph)

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

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. (____) _____

Spouse or other guarantor information (if different from above)

Name _____ Relation _____ Soc. Sec.# _____ Home Tel. (____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. (____) _____

INSURANCE INFORMATION

1.I0

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

❶

Employer _____

Bus. Address _____

Bus. Tel.# (____) _____ Plan _____

1.I1 **Ins. Co. Name** _____

Address _____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

Tel.# (____) _____ S.S.# _____

I.D.# _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.# (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

Tel.# (____) _____ S.S.# _____

I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer _____

Bus. Address _____

Bus. Tel.# (____) _____ Plan _____

1.I1 **Ins. Co. Name** _____

Address _____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

Tel.# (____) _____ S.S.# _____

I.D.# _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel.# (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

Tel.# (____) _____ S.S.# _____

I.D.# _____

Health History

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part 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
99.	Are you in good health? ..... Height Weight	❑	❑
100.	Have there been any changes in your general health in the past year?	❑	❑
101.	Are you under the care of a physician? ..... Date of last visit:	❑	❑
	If so, for what are you being treated?		
102.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
103.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? ..... If so describe where	❑	❑
104.	Do you have a prosthetic joint/implant? ..... If so, describe where	❑	❑
105.	Have you had a heart valve replacement or vascular graft?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain, angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Tuberculosis?			
120	Emphysema?			
121	Difficult breathing / other lung trouble?			
122	Do you smoke?			
123	Blood transfusion?			
124	Blood disorder such as anemia?			
125	Bruise easily?			
126	Bleeding tendency (abnormal bleed)?			
127	Jaundice, hepatitis or liver disease?			
128	Infectious mononucleosis?			
129	Gallbladder trouble?			
130	Fainting spells?			
131	Convulsions, epilepsy?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
132	Stroke?			
133	Thyroid trouble?			
134	Diabetes?			
135	Low blood sugar?			
136	Kidney trouble?			
137	Are you on dialysis?			
138	Swollen ankles, arthritis or joint disease?			
139	Stomach ulcers?			
140	Contagious diseases?			
141	Sexually transmitted diseases?			
142	Problems with the immune system?			
143	Delay in healing?			
144	A tumor or growth?			
145	X-Ray treatment / chemotherapy?			
146	Chronic fatigue / night sweats?			
147	Are you on a diet?			
148	A history of drug abuse?			
149	A history of alcohol abuse?			
150	Contact lenses?			
151	Eye disease / glaucoma?			
152	Mental health problems?			
153	A removable dental appliance?			
154	Pain & clicking of jaws when eating?			
155	Malignant hyperthermia?			
156	**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 8 hours?			
157	Who is driving you home?			

MEDICATION

ARE YOU NOW TAKING....	Yes	No	Notes	ARE YOU NOW TAKING....	Yes	No	Notes
201. Any kind of medicine, drugs, or pills?				205. Any kind of natural product, herbal supplement, or homeopathic remedy?			
202. Blood Thinners (i.e. Coumadin, Aspirin, Advil)?				**206. Please list any other medications you are taking:**			
203. Have you ever taken diet pills?							
204. Tranquilizers?							

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
207. Local anesthetics?				213. Other medications?			
208. Penicillin?				214. Latex?			
209. Other antibiotics?				215. Soy?			
210. Sodium pentothal, Valium, or other Tranquilizers?				216. Eggs / Yolk?			
211. Aspirin?				217. Sulfides?			
212. Codeine or other narcotics?				**218. Please list any allergies other than drug allergies:**			

WOMEN

219. Is there a possibility of pregnancy?				221. Are you nursing?			
220. Estimated delivery date? ___/___/___				222. 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 ❑

Do you wish to speak to the doctor privately about anything? ***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 ❑

IN CASE OF EMERGENCY, CONTACT: Name _____ Tel # H (____)_____ Wk # (____)_____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: ❑ Yes ❑ No Work Related: ❑ Yes ❑ No Other: ❑ Yes ❑ No

Date of Injury_____ Insurance Co. handling this claim _____ Claim # _____

Name of Attorney / Adjustor _____ Tel # (____) _____

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 m 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: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

Fees & Payments

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 manage depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any denta 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 fixe 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 balanc not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature *(Parent or Guardian if minor)*: X **Date:** X

This signature is my authorization to the information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me

Signature *(Parent or Guardian if minor)*: X **Date:** X

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice

Signature *(Parent or Guardian if minor)*: X **Date:** X

PATIENT: DO NOT WRITE BELOW THIS LINE!

bp____ T____ P____

Exam & Consult

Head, Neck, Face:

Oral Soft Tissue:

Maxilla, Mandible:

Teeth, Occlusion:

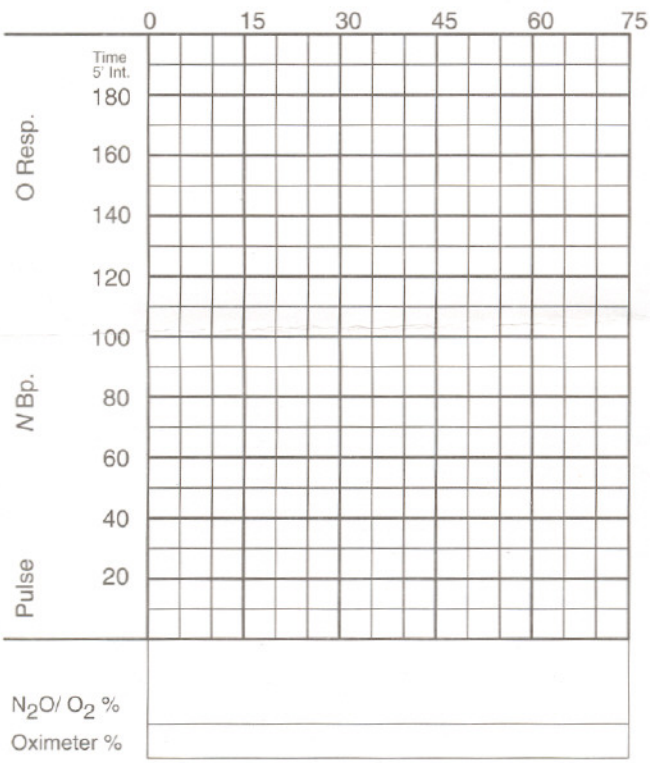
T.M. Joints:

Anesthesia Record

N.P.O. (Hours) _____

Date _____ ASA _____ Ht. _____ Wt. _____

Name _____ Age _____ Pre-op Bp. _____ T. _____ P. _____ R. _____



Anesthesia time _____ I.V. site: _____

Technique:

❑ I.V. ❑ IM. ❑ Inhalation

I.V. condition on D/C S U

Complications/Comments:

Agents:

Diazepam	_____	mg
Versed	_____	mg
Fentanyl	_____	cc
Brevital	_____	mg
Ketamine	_____	mg
Atropine	_____	mg
Decadron	_____	mg
Demerol	_____	mg
Phenergan	_____	mg
2% Xylocaine-Epi	_____	cc
3% Carbocaine	_____	cc
.5% Marcaine	_____	cc

Vital signs stable for D/C S___ U___

Discharge Condition: s___ u___

Disposition: _____

INDUCTION

s ____ u ____

Temp. _____

Anesthetist

MAINTENANCE

s ____ u ____

Pulse Ox _____

Assistant 1

Bp cuff _____

Assistant 2

RECOVERY

s ____ u ____

ECG _____

Assistant 3

DATE	NOTES