Under Welcome to our Practice

PATIENT INFORMATION:			Today's Date_	
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First N	ame	M.ILast Name		
Sex: ☐ Male ☐ Female Birth Date	e Age So	oc. Sec.#	E-mail	
Street	· · · · · · · · · · · · · · · · · · ·			
Home Tel.()	Cell.()	Have yo	ou ever been a patient of our pra	actice? 🗆 Yes 🗅 No
Referred By	LACTHAME	Has a family membe	er ever been a patient of our pra	ctice? 🗆 Yes 🗅 No
Dentist LAST NAME				
Driver's Lic.#				
Employer				
In case of emergency, please conta				
Will relation to the control of the				
WHO WILL BE RESPONSIBLE				·
☐ Self (If self, skip this section) ☐	**		Birth Date	
Name				
Street				
Driver's Lic.#				
SPOUSE OR OTHER GUAR				
		SS#	Birth D	ate
Name FIRST NAME LAST NA	ΔME			
Tel. ()				
INSURANCE INFORMATIO		Cabaal Nama and Addraga		
Student: Full Time		. School Name and Address $\frac{1}{80}$		
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maritar otataon =		CI	Do you belong to a PPO or HM	
mantar otataon =	Part Time 🔲 Retired 🗀 Not.	CI		O? 🖸 Yes 🚨 No
Employed:	Part Time Retired Not.	PRIMARY MEI	Do you belong to a PPO or HM	O? • Yes • No
PRIMARY DENTAL INSURA Employer Bus. Address	Part Time Retired Not. ANCE COMPANY: CITY STATE ZIP	PRIMARY MED Employer_ Bus. Address_ADDRES	Do you belong to a PPO or HM DICAL INSURANCE COM	O? • Yes • No IPANY: STATE ZIP
PRIMARY DENTAL INSURA Employer_ Bus. Address_ Bus. Tel.()	Part Time Retired Not. ANCE COMPANY: CITY STATE ZIP Plan	PRIMARY MED Employer_ Bus. Address_ ADDRES Bus. Tel.()	Do you belong to a PPO or HM DICAL INSURANCE COM S Plan	O? Yes No IPANY: STATE ZIP
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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 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?	0	
	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?	•	O.
	If so, describe where		
6.	Do you have a prosthetic joint / implant? If so, describe where	0	
7.	Have you had a heart valve replacement or vascular graft?	•	
8.	Have you ever had general anesthesia?	•	
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	•	
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	🗅	<u> </u>

III AV	T VOLUME OF TO VOLUME SUPPLIATIVE HAVE.	VEC	NO	NOTES
	E YOU HAD, OR DO YOU CURRENTLY HAVE: Rheumatic fever?	11-50	IVU	NOTE
12.	Damaged heart valves / mitral valve prolapse?			
13.	Heart murmur?			
14.	High blood pressure?			
15.	Low blood pressure?			
16.	Chest pain / angina?]
17.	Heart attack(s)?			i
18.	Irregular heart beat?			
19.	Cardiac pacemaker?			
20.	Heart surgery?			2
21.	Pneumonia, bronchitis, chronic cough?			
22.	Asthma?			
23.	Hay fever / sinus problems?			
24.	Snoring?			
25.	Sleep apnea / CPAP?			
26.				
27.	Tuberculosis?			
28.	Emphysema?			
29.	Do you smoke? If so, number of packs a day			
30.	Do you use chewing tobacco?			
31.	Blood transfusion?			
32.	Blood disorder such as anemia?			
33.	Bruise easily?			
34.	Bleeding tendency / abnormal bleed?			
35.	Hepatitis, jaundice, or liver disease?			
36.	Infectious mononucleosis?			
37.	Galibladder trouble?		L	

HAV	E YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
38.	Fainting spells?		
39.	Convulsions / epilepsy?		
40.	Stroke?		
41.	Thyroid trouble?		
42.	Diabetes?		
43.	Low blood sugar?		
44.	Kidney trouble?		
45.	High cholesterol?		
46.	Are you on dialysis?		
47.	Swollen ankles / arthritis / joint disease?		
48.	Osteoporosis / osteopenia?		
49.	Osteonecrosis?		
50.	Stomach ulcers / acid reflux?		
51.	Contagious diseases?		
52.	Sexually transmitted diseases?		
53.	Problems with immune system? Possibly from medication / surgery, etc.		
54.	Delay in healing?		
55.	A tumor or growth?		
56.	Cancer / radiation therapy / chemotherapy?		
57.	Chronic fatigue / night sweats?		
58.	Are you on a diet?		
59.	A history of alcohol abuse?		
60.	A history of drug abuse?		
61.	Contact lenses?		
62.	Eye disease / glaucoma?	<u> </u>	
63.	Mental health problems / anxiety / depression?		
64.	A removable dental appliance?	<u> </u>	
65.	Pain or clicking of jaws when eating?		

WOMEN ONLY: (QUESTIONS 66-69))	<u> </u>						
66. Is there a possibility of pregnancy? 67. Expected delivery date?			No 	68. Are you nursing?		No		
Note: Antibiotics (such as penicillin) may alter the effect	iveness of b	oirth control p	oills. Cons	sult your physician / gynecologist for assistance regarding other methods o	birth coi	ntrol.		
ARE YOU NOW TAKING:	YES NO	NOTE	2	ARE YOU ALLERGIC TO, OR HAD A REACTION TO: YES NO	NO	TES		
70. Any kind of medication, drug, pills?	11-6 110	HUILA		77. Local anesthetic (numbing meds.)?	H.V	ILO		
71. Blood thinners (Coumadin, Plavix,				78. Penicillin?				
Aspirin, Vitamin E, Ginko biloba,				79. Other antibiotics?				
Aggrenox, Pradaxa, Fish oil)?				80. Sulfa drugs?				
72. Have you ever taken diet pills?				81. Sodium pentothal / Valium /other tranquilizers?				
73. Any natural product, herbal				82. Aspirin?				
supplement or homeopathic remedy?				83. Amoxicillin?				
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphos-				84. Codeine or other narcotics?				
phonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast,				85. Latex?				
or Evista in the past 12 years?				86. Soy?				
75. Tranquilizers, sleeping pills, anti-depressant	ts, and/or	narcotics o	n a	87. Eggs / yolk?				
regular basis? If so, please list:				88. Sulfites?				
				89. Do you have any known allergies?				
76. Please list any medications you are current	1 1	_		90. Please list any allergies other than drug allergies:				
Medication	Dosage	Frequer	icy					
	-							
				An international contribution or region, common actions and page from a first contribute or contribute or contribute or contribute or an international contribute or contr	and which the same			
				91. Please list any other medication or antibiotic you are allergic to:				
				Medication / Antibiotic Name				
	-							
	-							
-								
				Is there a family history of:				
				☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthe	sia prob	olems		
				Is this visit related to an accident? ☐ Yes ☐ No				
If you are having surgery today , have you had in the last 6 (six) hours? \square Yes \square No	anything t	o eat or dri	ink	If Yes, what type of accident? Automobile Work relationships Automobile Work relationships Work relat	ated 🗆	Other		
Who is driving you home?				Date of injury				
				Insurance company handling the claim				
Is there any condition concerning your health the told about? ☐ Yes ☐ No – If Yes, describe	nat the Do	octor should	a	Claim number				
		7 July 200		Name of attorney / adjustor				
Do you wish to speak to the Dr. privately about anything? \(\) Yes \(\) No Telephone number ()_								

I certify that I have read and I understand the questions abostisfaction. I will not hold my doctor, or any other member of						
хх	X		X			
X Signature of patient (Parent or Guardian if Minor)	Date	Reviewed by	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. Other arrangements can be made with our office manager 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 dental 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 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 for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.						
X			X			
X Signature of patient (Parent or Guardian if Minor)			Date			
This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. X						
Signature of patient: (Parent or Guardian if Minor)			Date			
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. 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. X						
Signature of patient (Parent or Guardian if Minor)		Doctor	Date			
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			