# Welcome to our Practice

## PATIENT INFORMATION:

**Today's Date** _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name_____ M.I._____ Last Name _____

Sex: ☐ Male ☐ Female Birth Date_____ Age_____ Soc. Sec. #_____ E-Mail _____

Street_____Apt._____City_____ State_____ Zip _____

Home Tel: (_____)_____ Cell: (_____) _____Have you ever been a patient of our practice? ☐Yes ☐ No

Referred By_____ _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No
FIRST NAME LAST NAME

Dentist_____ _____ Orthodontist_____ _____ Medical Dr._____ _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST MAME LAST NAME

Driver's Lic.#_____ Nearest relative not living with you _____ _____ Tel. No. (_____) _____
FIRST NAME LAST NAME

Employer_____ Bus. Tel. (_____) _____Personal Payment Type: ☐ Cash ☐ Check ☐ Credit Card

In case of emergency, please contact_____ Tel. (_____) _____ Relation_____

## WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name_____ _____ S.S.#_____ Birth Date_____ Age_____
FIRST NAME LAST NAME

Tel.(_____)_____ Cell. (_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip _____

Driver's Lic. #_____ Employer_____ Bus. Tel. (_____)_____

## SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ _____ Relation_____ S.S.#_____ Birth Date _____
FIRST NAME LAST NAME

Street_____ Apt._____ City_____ State_____ Zip

Tel. (_____) _____ Employer_____ Bus. Tel. (_____) _____

## INSURANCE INFORMATION:

**Student**..... ☐ Full time ☐ Part Time ☐ Not.....School Name and Address _____

**Marital Status**...☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated_____ _____ _____
CITY STATE ZIP

**Employed**..... ☐ Full Time ☐ Part Time ☐ Retired ☐ Not.....Do you belong to a PPO or HMO? . ☐ Yes ☐No

## PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____)_____ Plan_____

Ins. Co. Name_____ I.D.#_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ Birth Date_____ Sex: ☐ M ☐ F

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

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

## PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____)_____

Ins. Co. Name_____ I.D. #_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel. (_____)_____ Group Name_____

Group #_____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ Date of Birth_____ Sex: ☐ M ☐ F

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

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

## SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Business Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____)_____Plan_____

Ins. Co. Name_____ I.D #_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel. (_____)_____ Group Name_____

Group #_____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ Birth Date_____ Sex: ☐ M ☐ F

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

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

## SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (_____)_____

Ins. Co. Name_____ I.D. #_____

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Tel. (_____)_____ Group Name_____

Group #_____ Insured Party_____ _____
FIRST NAME LAST NAME

Relation_____ Date of Birth_____ Sex: ☐ M ☐ F

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

Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

## HISTORY OF HEALTH:

**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.*

| | Yes | No |
|---|---|---|
| Reason for today's office visit?_____ | | |
| 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? ***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? ***If so, describe where***_____ | ☐ | ☐ |
| 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 an unusual or serious reactions to general anesthesia? | ☐ | ☐ |
| 10. 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 | NOTES |
|---|---|---|---|
| 11. Rheumatic Fever? | | | |
| 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)? | | | |
| 18. Irregular heart beat? | | | |
| 19. Cardiac pacemaker? | | | |
| 20. Heart surgery? | | | |
| 21. Pneumonia, bronchitis, chronic cough? | | | |
| 22 . Asthma? | | | |
| 23. Hay fever / sinus problems? | | | |
| 24. Snoring? | | | |
| 25. Sleep apnea / CPAP? | | | |
| 26. Difficult breathing / other lung problem? | | | |
| 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 / abdominal bleed? | | | |
| 35. Hepatitis, jaundice, or liver disease? | | | |
| 36. Infectious mononucleosis? | | | |
| 37. Gallbladder trouble? | | | |

| HAVE YOU HAD, OR DO YOU CURRENTLY HAVE | YES | NO | NOTES |
|---|---|---|---|
| 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 glasses / glaucoma? | | | |
| 63. Mental health problems / anxiety depression? | | | |
| 64. A removable dental appliance? | | | |
| 65. Pain or clicking of jaws when eating? | | | |

## WOMEN ONLY: *(QUESTIONS 66-69*

| | Yes | No |
|---|---|---|
| 66. Is there a possibility of pregnancy? | ☐ | ☐ |
| 67. Expected delivery _____ | | |
| 68. Are you nursing? | ☐ | ☐ |
| 69. Are you taking birth control pills? | ☐ | ☐ |

**Note:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist regarding other methods of birth control.

| ARE YOU NOW TAKING: | YES | NO | NOTES |
|---|---|---|---|
| 70. Any kind of medication, drug, pills? | | | |
| 71. Blood thinners, (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish Oil? | | | |
| 72. Have you ever taken diet pills? | | | |
| 73. Any natural product, herbal supplement or homeopathic remedy? | | | |
| 74. Are you taking, or have you ever taken bone density meds, PANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years? | | | |

75. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

_____

_____

76. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ☐ Methadone ☐ Suboxone ☐ Oxycodone ☐ Fentanyl ☐ Other_____

Treating doctor: _____ _____
FIRST NAME LAST NAME

77. Please list any medications you are currently taking:

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| ARE YOU ALLERGIC TO, OR HAD A REACTION TO: | YES | NO | NOTES |
|---|---|---|---|
| 78. Local anesthetic (numbing meds.)? | | | |
| 79. Penicillin? | | | |
| 80. Other antibiotics? | | | |
| 81. Sulfa drugs? | | | |
| 82. Sodium pentothal/Valium other tranquilizers? | | | |
| 83. Aspirin? | | | |
| 84. Amoxicillin? | | | |
| 85. Codeine or other narcotics? | | | |
| 86. Iodine? | | | |
| 87. Do you have any known allergies? | | | |

88. Please list any allergies, other drug allergies and non-drug allergies:

89. Please list any other medication or antibiotic you are allergic to:
Medication/Antibiotic Name

# PATIENT DENTAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Does your gums bleed while brushing or flossing? | ☐ | ☐ |
| 2. Are your teeth sensitive to hot or cold liquids/foods? | ☐ | ☐ |
| 3. Are your teeth sensitive to sweet or sour liquids/foods? | ☐ | ☐ |
| 4. Do you feel pain to any of your teeth? | ☐ | ☐ |
| 5. Do you have any sores or lumps in or near your mouth? | ☐ | ☐ |
| 6. Have you had any head, neck, or jaw injuries? | ☐ | ☐ |
| 7. Have you ever experienced any of the following problems in your jaw? | | |
| a) Clicking? | ☐ | ☐ |
| b) Pain (joint, ear, side of face)? | ☐ | ☐ |
| c) Difficulty in opening or closing? | ☐ | ☐ |
| d) Difficulty in chewing? | ☐ | ☐ |
| 8. Do you have frequent headaches? | ☐ | ☐ |
| 9. Do you clench or grind your teeth? | ☐ | ☐ |
| 10. Do you bite your lips or cheeks frequently? | ☐ | ☐ |
| 11. Have you ever had any difficult extractions in the past? | ☐ | ☐ |
| 12. Have you had any orthodontic work? | ☐ | ☐ |
| 13. Have you ever had any prolonged bleeding following extractions? | ☐ | ☐ |
| 14. Have you ever had instructions on the correct method of brushing your teeth? | ☐ | ☐ |
| 15. Have you ever had instructions on the care of your gums? | ☐ | ☐ |

Comments: _____

_____

_____

_____

**I certify** that I have read and I understand the above questions. 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 this/her staff, responsible for any errors or omissions that I have made in the completion of this form.

X_____ X_____ X_____ X_____
**Signature of patient** *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

## FEES AND 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 of this form.

Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedure 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_____
**Signature of patient** *(Parent or Guardian if Minor)* **Date**

This signature of 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_____ X_____
**Signature of patient** *(Parent or Guardian if Minor* **Date**

## AUTHORIZATION

I authorize my dentist 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 required 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_____ X_____ 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**