Welcome to our Practice

PATIENT INFORMATION

Registration Type: Patient **Date: 12/27/2024**

Prefix	**First Name**	**Middle Name**	**Last Name**
Date of birth		**Social Security Number**	
Email		**Gender**	
Street Address 1			
Street Address 2			
Apt.		**City**	
State		**Zip**	
Primary Phone		**Alternate Phone (Mobile, work, or home)**	
Have you ever been a patient of our practice? no		**Has a family member ever been a patient of our practice?**	
Dentist First Name		**Dentist Last Name**	
Orthodontist First Name		**Orthodontist Last Name**	
Medical Doctor First Name		**Medical Doctor Last Name**	
Referred by First Name		**Referred by Last Name**	
Preferred Pharmacy Name		**Preferred Pharmacy Phone**	
Nearest relative not living with you			
First Name		**Last Name**	
Relative Phone		**Personal Payment Type**	

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

___(If self, skip this section)

First Name	**Last Name**
Date of birth	**Social Security Number**
Home Phone	**Mobile Phone**
Email	
Street Address 1	
Street Address 2	
Apt.	**City**
State	**Zip**
Employer/Business Name	**Primary Phone**

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FORM ABOVE):

First Name	**Last Name**
Relative Phone	**Birth Date**
Soc. Sec.	

Street 1	
Street 2	
Apt.	**City**
State	**Zip**
Employer/Business Name	**Home Phone**
Business Phone	

INSURANCE INFORMATION

Employed Type **Marital status** **Student Type**
School Name

PRIMARY DENTAL INSURANCE INFORMATION	PRIMARY MEDICAL INSURANCE INFORMATION
Primary Dental Insurance Subscriber First Name	**Primary Medical Insurance Subscriber First Name**
Last Name	**Last Name**
Patients Relationship to Subscriber	**Patients Relationship to Subscriber**
Date of birth	**Date of birth**
Insured Party Gender	**Insured Party Gender**
Insured Party Phone	**Insured Party Phone**
Social Security Number	**Social Security Number**
Insured Party Address 1	**Insured Party Address 1**
Insurance Party Address 2	**Insurance Party Address 2**
City	**City**
State	**State**
Zip	**Zip**
Primary Dental Insurance Information Employer / Business	**Primary Medical Insurance Information Employer / Business**
Phone Number	**Phone Number**
Plan Name	**Plan Name**
Ins. Company Name	**Ins. Company Name**
Policy I.D. Number	**Policy I.D. Number**
Ins. Company Address 1	**Ins. Company Address 1**
Ins. Company Address 2	**Ins. Company Address 2**
City	**City**
State	**State**
Zip	**Zip**
Phone Number	**Phone Number**
Group Name	**Group Name**
Group Number	**Group Number**

Do you have secondary dental or medical insurance?: No

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.

What is your reason for visiting our practice?

What is your height	**What is your weight**	**Health Status**

Have there been any changes in your general health in the past year?

Are you under the care of a physician?

Have you had any illness, operation or been hospitalized in the past five years?

If so, describe

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?

If so, describe

Do you have a prosthetic joint/implant?

If so, describe

Have you had a heart valve replacement or vascular graft?

If so, describe

Have you ever had general anesthesia?

If so, describe

Have you, or a family member, had any unusual or serious reactions to general anesthesia?

If so, describe

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

If so, describe

Is there any condition concerning your health that the doctor should be told about?

If so, describe

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

If so, describe

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours?

Who is driving you home?

Mobile Phone

Notify of Pick-up status via

Is there a FAMILY history of

Cancer	**Diabetes**	**Heart Disease**
Anesthesia Problems	**Autism**	

HEALTH HISTORY PART 2

Rheumatic fever	**Fainting spells**
Damaged heart valves/mitral valve prolapse	**Convulsions / epilepsy**
Heart murmur	**Stroke**
High blood pressure	**Thyroid trouble**
Low blood pressure	**Diabetes**
Chest pain / angina	**Low blood sugar**

Heart attack(s)	**Kidney trouble**
Irregular heart beat	**High cholesterol**
Cardiac pacemaker	**Are you on dialysis?**
Heart surgery	**Swollen ankles, arthritis or joint disease**
Pneumonia, bronchitis or chronic cough	**Osteoporosis/ osteopenia**
Asthma	**Osteonecrosis**
Hay fever / sinus problems	**Stomach ulcers/ acid reflux**
Snoring	**Sexually transmitted disease**
Sleep Apnea / CPAP	**Problems with the immune system? Possibly from medication/ surgery, etc.**
Difficult breathing/other lung trouble	**Delay in healing**
Tuberculosis	**A tumor or growth**
Emphysema	**Cancer, radiation therapy or chemotherapy**
Do you smoke or vape?	**Chronic fatigue/ night sweats**
If so, how much a day?	**Are you on a diet?**
Do you use marijuana?	**A history of alcohol abuse**
Do you use chewing tobacco?	**A history of drug use?**
Blood transfusion	**Contact lenses**
Blood disorder such as anemia	**Eye disease/ glaucoma**
Bruise easily	**Mental health problems/ anxiety/ depression**
Bleeding tendency/ abnormal bleed	**Removable dental appliance**
Hepatitis, jaundice, or liver disease	**Pain and clicking of jaws when eating**
Infectious mononucleosis	**Contagious diseases**
Gallbladder trouble	
HIV/AIDS	

WOMEN ONLY

Is there a possibility of pregnancy?	**Expected delivery date?**
Are you nursing?	**Are you taking birth control pills?**
Date of your last period?	

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.

MEDICATIONS / ALLERGIES

Medications (Are you now taking...)

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)

Have you ever taken diet pills

Any natural product, herbal supplement or homeopathic remedy

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?

Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis. If yes, please list:

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(Percocet)	
Fentanyl	
Other	
Other Description	
Treating Doctor First Name	
Treating Doctor Last Name	

Are you taking any kind of medication, drug, pills?	
Allergies	
Local anesthetic (numbing medication)	**Penicillin/Amoxicillin**
Other antibiotics	**Sulfa Drugs**
Sodium pentothal, Valium, or other tranquilizers	**Aspirin**
Amoxicillin	**Codeine or other narcotics**
Latex	**Soy**
Eggs/Yolk	**Sulfites**
Do you have any known allergies?	**Please list any allergies other than drug allergies?**
Please list any other medications or antibiotics you are allergic to.	

PATIENT SCREENING FORM

	PRE APPOINTMENT IN OFFICE
Do you/they have fever or have you/they felt hot or feverish recently?	
Are you/they having shortness of breath or other difficulties breathing?	
Do you/they have a cough?	
Any other flu like symptoms, such as gastrointestinal upset, headache or fatigue?	
Have you/they experienced recent loss of taste or smell?	
you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	
Is your/their age over 60?	
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.
For testing, see the list of State and Territorial Health Department Websites for your specific area's information.
I fully understand and agree, according to state regulations, that I will contact the office if I develop any of the symptoms above within seven days visiting and / or being treated by this office

CONCLUSION

Emergency Contact First Name	**Emergency Contact Last Name**
Home Phone	**Mobile Phone**
Relationship to Patient	
Accident **Is this related to an accident?**	
If Yes, What type?	
Date of Injury	
Insurance Company Handling This Claim	**Insurance Claim Number**
Name of Attorney / Adjustor	**Attorney / Adjustor Phone**

Verification

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.

Sign	Date
	12/27/2024

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.

Sign	Date
	12/27/2024

Release of Information

This signature on file is my authorization for the release of information necessary to process my claim. Reimbursement will go to patient.

Sign	Date
	12/27/2024

Authorization for Service

I authorize my surgeon and 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.

Sign	Date
	12/27/2024

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.

Sign	Date
	12/27/2024