Welcome to our Practice

PATIENT INFORMATION:

First Name: _____ Middle Initial: ___ Last Name: _____ Date: ___/___/_____

Birthdate: ___/___/_____ Soc. Sec. #: _____-_____-_____ Email: _____ Sex: _____

Street 1: _____ Street 2: _____

Apartment #: _____ City: _____ State: _____ ZIP: _____

Home Tel: _____ Mobile Tel: _____ Referred By: _____

Have you ever been a patient of our practice? Y / N Has a family member ever been a patient of our practice? Y / N

Referring Dentist: _____ Orthodontist: _____ Medical Dr.: _____

Preferred Pharmacy: _____ Tel: _____ Payment Type: Check / Credit / Cash

Nearest relative not living with you: _____ Tel: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Relationship: *(Please circle one. If self, skip this section)* Self / Spouse / Father / Mother / Other: _____

First Name: _____ Last Name: _____

Birthdate: ___/___/_____ Soc. Sec. #: _____-_____-_____ Email: _____

Street 1: _____ Street 2: _____

Apartment #: _____ City: _____ State: _____ ZIP: _____

Home Tel: _____ Mobile Tel: _____

Employer/Business Name: _____ Business Phone: _____

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

First Name: _____ Last Name: _____ Phone: _____

Birthdate: ___/___/_____ Soc. Sec. #: _____-_____-_____ Email: _____

Street 1: _____ Street 2: _____

Apartment #: _____ City: _____ State: _____ ZIP: _____

INSURANCE INFORMATION:

Employment Type: *(Please circle one)* Full Time / Part Time / Retired / Not Employed

Marital Status: *(Please circle one)* Single / Married / Divorced / Widow / Legally Separated

Student Status: *(Please circle one)* Full Time / Part Time / Not a student School Name: _____

PRIMARY DENTAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/____ Soc. Sec. #: _____-_____-_____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/____ Soc. Sec. #: _____-_____-_____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY DENTAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/____ Soc. Sec. #: _____-_____-_____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/____ Soc. Sec. #: _____-_____-_____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

HEALTH HISTORY

To our patients: Although we primarily treat the area in and area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication 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 (in inches)? _____

What is your weight (in lbs)? _____

Are you in good health? .....Y / N

Have there been any changes in your general health in the past year ?.....Y / N

Are you under the care of a physician?.....Y / N

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

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

Do you have a prosthetic joint/implant?.....Y / N

Have you had a heart valve replacement or vascular graft? .....Y / N

HEALTH HISTORY CONT.

Have you ever had general anesthesia?.....Y / N

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

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

Is there any condition concerning your health that the doctor should be told about?.....Y / N

Do you wish to speak to the doctor privately about anything? .....Y / N

IS THERE A FAMILY HISTORY OF:

Cancer? .....Y / N

Heart Disease ?.....Y / N

Autism?.....Y / N

Diabetes?.....Y / N

Anesthesia Problems?.....Y / N

WOMEN ONLY

Is there a possibility of pregnancy? .....Y / N

If yes, expected delivery date? _____

Are you nursing? .....Y / N

Are you taking birth control pills? .....Y / N

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.

Continued on next page.

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Rheumatic fever? ..... Y / N
Damaged heart valves/mitral valve prolapse? ..... Y / N
Heart murmur? ..... Y / N
High blood pressure? ..... Y / N
Low blood pressure? ..... Y / N
Chest pain / angina? ..... Y / N
Heart attack(s)? ..... Y / N
Irregular heart beat? ..... Y / N
Cardiac pacemaker? ..... Y / N
Heart surgery? ..... Y / N
Pneumonia, bronchitis or chronic cough? ..... Y / N
Asthma? ..... Y / N
Hay fever / sinus problems? ..... Y / N
Snoring? ..... Y / N
Sleep apnea / CPAP? ..... Y / N
Difficulty breathing / other lung trouble? ..... Y / N
Tuberculosis? ..... Y / N
Emphysema? ..... Y / N
Blood transfusion? ..... Y / N
Blood disorder such as anemia? ..... Y / N
Bruise easily? ..... Y / N
Bleeding tendency / abnormal bleed? ..... Y / N
Hepatitis, jaundice, or liver disease? ..... Y / N
Infectious mononucleosis? ..... Y / N
Gallbladder trouble? ..... Y / N
HIV / AIDS? ..... Y / N

Do you smoke or vape? ..... Y / N
If so, how much per day? ..... _____

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Fainting spells? ..... Y / N
Convulsions / epilepsy? ..... Y / N
Stroke? ..... Y / N
Thyroid trouble? ..... Y / N
Diabetes? ..... Y / N
Low blood sugar? ..... Y / N
Kidney trouble? ..... Y / N
High cholesterol? ..... Y / N
Swollen ankles, arthritis or joint disease? ..... Y / N
Osteoporosis / osteopenia? ..... Y / N
Osteonecrosis? ..... Y / N
Stomach ulcers / acid reflux? ..... Y / N
Contagious diseases? ..... Y / N
Sexually transmitted diseases? ..... Y / N
Problems with immune system? ..... Y / N
Delay in healing? ..... Y / N
A tumor or growth? ..... Y / N
Cancer, radiation therapy or chemotherapy? ..... Y / N
Chronic fatigue / night sweats? ..... Y / N
A history of alcohol abuse? ..... Y / N
A history of marijuana or other drug use? ..... Y / N
Contact lenses? ..... Y / N
Eye disease / glaucoma? ..... Y / N
Mental health problems / anxiety / depression? ..... Y / N
A removable dental appliance? ..... Y / N
Pain or clicking of jaws when eating? ..... Y / N
Do you use marijuana? ..... Y / N
Do you use chewing tobacco? ..... Y / N
Are you on a diet? ..... Y / N

Continued on next page.

ARE YOU NOW TAKING:

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish oil)? ..... Y / N

Have you ever taken diet pills? ..... Y / N

Any natural product, herbal supplement or homeopathic remedy? ..... Y / N

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 ?..... Y / N

Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis.... Y / N

If yes, please list:

_____

If you are under the care of a physician for pain management or recovering from drug addiction please circle the medication you are currently taking:

Methadone / Suboxone / Oxycodone / Fentanyl / Other

If Other, description:

_____

Doctor name:_____

Are you taking any kind of medication, drug, pills?Y / N

(if yes, list below)

Medication Dosage Frequency

_____
_____
_____
_____
_____
_____
_____
_____

Who is driving you home?_____

Mobile Number_____Pick-up status_____

ARE YOU ALLERGIC OR HAD A REACTION TO:

Local anesthetic (numbing medication) ..... Y / N

Penicillin ..... Y / N

Other antibiotics ..... Y / N

Sulfa Drugs..... Y / N

Sodium pentothal, Valium, or other tranquilizers .. Y / N

Aspirin ..... Y / N

Amoxicillin..... Y / N

Codeine or other narcotics..... Y / N

Latex ..... Y / N

Soy ..... Y / N

Eggs/Yolk..... Y / N

Sulfites ..... Y / N

Do you have any known Allergies ..... Y / N

Please list any allergies other than drug allergies.

_____

Please list any other medications or antibiotics you are allergic to.

_____
_____
_____
_____

Conclusion

Emergency Contact: First Name: _____ Last Name: _____

Home Tel:_____ Cell:_____ Relation:_____

Is this related to an accident? Y / N If yes, what type? _____ Date of Injury_____

Insurance company handling this claim: _____ Insurance Claim Number _____

Name of Attorney/Adjustor: _____ Attorney/Adjustor Phone: _____

Signatures

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.

_____ _____

Signature Date

Fees & Payments

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.

_____ _____

Signature Date

Authorization for Service

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.

_____ _____

Signature Date

Notice of Privacy Practices

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.

_____ _____

Signature Date