Welcome
Welcome
Welcome

Welcome To Our Practice

PATIENT INFORMATION

Date ____________

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ____________ M.I. ____ Last Name ____________ Nickname ____________

Sex: ❑ Male ❑ Female Birth Date ____________ Age ____ Soc. Sec. # ____________ E-mail ____________

Street ____________ City ____________ State ____ Zip ____________

Home Tel.(____) ____________ Cell.(____) ____________ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist ____________ Medical Doctor ____________ Referred By ____________

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

Employer ____________ Bus. Tel.(____) ____________ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other ____________

Name ____________ S.S.# ____________ Birth Date ____________ Age ____ Tel.(____) ____________

Street ____________ City ____________ State ____ Zip ____________

Employer ____________ Bus. Tel.(____) ____________

Spouse or other guarantor information (*if different from above*)

Name ____________ Relation ____________ S.S.# ____________ Tel.(____) ____________

Street ____________ City ____________ State ____ Zip ____________

Employer ____________ Bus. Tel.(____) ____________

INSURANCE INFORMATION

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

Employer ____________
Bus. Address ____________
Bus. Tel.(____) ____________ Plan ____________
Ins. Co. Name ____________
Address ____________
____________ Tel.(____) ____________
Group # ____________ Group Name ____________
Insured Party ____________ Relation ____________
Sex: ❑ M ❑ F Birth Date ____________
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 Birth Date ____________
Street ____________
City, State, Zip ____________
Tel.(____) ____________ S.S. # ____________
I.D. # ____________

SECONDARY DENTAL INSURANCE COMPANY

Employer ____________
Bus. Address ____________
Bus. Tel.(____) ____________ Plan ____________
Ins. Co. Name ____________
Address ____________
____________ Tel.(____) ____________
Group # ____________ **Group Name** ____________
Insured Party ____________ Relation ____________
Sex: ❑ M ❑ F Birth Date ____________
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 Birth Date ____________
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? *If so, describe* ________	❑	❑
103. Do you have unhealed/recurrent 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 Snoring / sleep apnea?			
120 Difficult breathing / other lung trouble?			
121 Tuberculosis?			
122 Emphysema?			
123 Do you smoke?			
124 Do you use chewing tobacco?			
125 Blood transfusion?			
126 Blood disorder such as anemia?			
127 Bruise easily?			
128 Bleeding tendency / abnormal bleed?			
129 Hepatitis, jaundice, or liver disease?			
130 Infectious mononucleosis?			
131 Gallbladder trouble?			
132 Fainting spells?			
133 Convulsions / epilepsy?			
134 Stroke?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	*Yes*	*No*	*NOTES*
135 Thyroid trouble?			
136 Diabetes?			
137 Low blood sugar?			
138 Kidney trouble?			
139 Are you on dialysis?			
140 Swollen ankles, arthritis or joint disease?			
141 Osteoporosis / Osteopenia?			
142 Osteonecrosis			
143 Stomach ulcers?			
144 Contagious diseases?			
145 Sexually transmitted diseases?			
146 Are you immunosuppressed? possibly from transplant surgery, etc.			
147 Problems with the immune system? possibly from medication / surgery, etc.			
148 Delay in healing?			
149 A tumor or growth?			
150 Radiation therapy / chemotherapy?			
151 Chronic fatigue / night sweats?			
152 Are you on a diet?			
153 A history of drug abuse?			
154 A history of alcohol abuse?			
155 Contact lenses?			
156 Eye disease / glaucoma?			
157 Mental health problems?			
158 A removable dental appliance?			
159 Pain and clicking of jaws when eating?			
160 Malignant hyperthermia?			
161 **IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
162 Who is driving you home?			

MEDICATION - Are you now taking. . .

		Yes	No	NOTES
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			

206 Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:

207 Please list any medications you are currently taking:

____

____

ALLERGIES - Are you allergic to, or had a reaction to. . .

		Yes	No	NOTES
208	Local anesthetic (numbing med.)?			
209	Penicillin?			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Valium, or other tranquilizers?			
213	Aspirin?			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolk?			
219	Sulfites?			

220 Please list any allergies other than drug allergies:

Is there any condition concerning your health that the Doctor should be told about?
❑ Yes ❑ No (*if so, describe*) ______________________

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 ______________________

Home Tel.(_____) ______________________

Bus. Tel.(_____) ______________________

IS THIS VISIT RELATED TO AN ACCIDENT?

Automobile: ❑ Yes ❑ No
Work Related: ❑ Yes ❑ No
Other: ❑ Yes ❑ No

Date of Injury ______________________

Insurance company handling this claim ______________________

Claim number ______________________

Name of Attorney / Adjustor ______________________

Telephone Number (_____) ______________________

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

401 Is there a possibility of pregnancy? ❑ Yes ❑ No

402 Expected delivery date _____ / _____ / _____

403 Are you nursing? ❑ Yes ❑ No

404 Are you taking birth control pills? ❑ Yes ❑ No

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.*

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 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 and 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 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.

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

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.

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

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.

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

PATIENT: DO NOT WRITE BELOW THIS LINE!

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Permanent

R	a	b	c	d	e	f	g	h	i	j	L
	t	s	r	q	p	o	n	m	l	k	

Deciduous

bp____ T____ P____

Exam and 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. ________

	0	15	30	45	60	75
Time 5' Int.						
180						
160						
140						
120						
100						
80						
60						
40						
20						
N_2O/O_2 %						
Oximeter %						

O Resp.

N Bp.

Pulse

Anesthesia Time ________

Technique:

❑ I.V. ❑ IM. ❑ Inhalation

Agents:

Diazepam	________	mg
Versed	________	mg
Fentanyl	________	ml
Brevital	________	mg
Ketamine	________	mg
Atropine	________	mg
Propofol	________	mg
Nubain	________	mg
Decadron	________	mg
Demerol	________	mg
Phenergan	________	mg
2% Xylocaine-Epi	________	ml
3% Carbocaine	________	ml
0.5% Marcaine	________	ml
4% Articaine-Epi	________	ml

____

____

I.V. Site ________

I.V. Condition on D/C: S U

Complications/Comments:

____

Vital signs stable for D/C: S ___ U ___

Discharge Condition: S ___ U ___

Disposition: ________

INDUCTION:

s ______ u ______

MAINTENANCE:

s ______ u ______

RECOVERY:

s ______ u ______

Temp. ________

Pulse Ox ________

Bp Cuff ________

ECG ________

Anesthetist

Assistant 1

Assistant 2

Assistant 3

DATE	NOTES