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: _____

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.

_____
_____
_____
_____

Family history of cancer? ..... Y / N

Family history of diabetes? ..... Y / N

Family history of heart disease? ..... Y / N

Family history of anesthesia problems? ..... Y / N

Family history of autism? ..... Y / N

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

Describe:_____

_____

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

Describe_____

_____

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

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