PATIENT INFORMATION SHEET

Date _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Sex ☐ Male ☐ Female Birthdate _____ Age_____ Marital Status _____

Address _____ City _____ State_____ Zip_____

Home/ Cell phone _____ Email _____ SSN#_____

Employer _____ Work Phone _____

Physician _____ Dentist _____ Referred by _____

Person to contact if emergency _____ Phone _____

RESPONSIBLE PARTY

Person responsible for account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home/Cell Phone_____ Social Security _____ Birthdate_____

INSURANCE INFORMATION

Name of Subscriber _____ Your Relationship to Subscriber _____

Subscriber Address (if different than patient) _____ ☐ Male ☐ Female

Subscriber Phone _____Subscriber Birthdate _____ SSN#_____

Insurance Company Name _____ Insurance Phone #_____

Insurance Address _____

Subscriber/Member ID# _____ Group #_____

Employer _____ Does you plan cover ☐ Dental ☐ Medical ☐ Both

SECONDARY INSURANCE INFORMATION

Name of Subscriber _____ Your Relationship to Subscriber _____

Subscriber Address (if different than patient) _____ ☐ Male ☐ Female

Subscriber Phone_____Subscriber Birthdate _____ SSN# _____

Insurance Company Name _____ Insurance Phone #_____

Insurance Address _____

Subscriber/Member ID# _____ Group #_____

Employer _____ Does you plan cover ☐ Dental ☐ Medical ☐ Both

FEES AND PAYMENTS

Please remember that insurance is considered a method of reimbursing the patient for fees paid and is not a substitute for payment to the doctor. It is your responsibility to pay any deductible, co-payment, or any other balance due. We are not responsible for enforcing divorce decrees or separation agreements. Medicare does not cover surgery involving teeth and gums. Fees are based on the cost of delivering care and not on the fee an insurance company considers usual, customary, and reasonable.

This signature on file is my authorization for release of information necessary to process my claim. I hereby authorize payment directly to the doctor.

Signature _____

---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 important interrelationships with your care. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

A.

	YES	NO
1. What is your **Height**? ____'_____" Your **Weight**? _____lbs.		
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 ever been in the hospital or had surgery?	☐	☐
If yes, explain: _____		
5. Do you smoke? (*If yes,* _____ ***packs per day for*** _____ ***years***)	☐	☐
6. Do you drink alcohol? (*If yes,* ***how much per day*** _____)	☐	☐
7. Do you use recreational drugs, such as cocaine, marijuana, etc.?	☐	☐

B.

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	YES	NO
Heart Attack?	☐	☐
Heart Failure?	☐	☐
Angina? (Chest pain)	☐	☐
Irregular Heartbeat?	☐	☐
Heart Surgery?	☐	☐
Heart Murmur?	☐	☐
Pacemaker?	☐	☐
High Blood Pressure?	☐	☐
Low Blood Pressure?	☐	☐
Artificial Heart Valve?	☐	☐
Mitral Prolapse?	☐	☐
Congenital Heart Disease? ...	☐	☐
Stroke?	☐	☐
Fainting or Dizzy Spells?	☐	☐
Asthma?	☐	☐
Emphysema?	☐	☐
Bronchitis?	☐	☐
Cancer?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	YES	NO
Shortness of Breath?	☐	☐
Hiatal Hernia, Heartburn?	☐	☐
Tuberculosis?	☐	☐
Allergies or Hives?	☐	☐
Seizures?	☐	☐
Sickle Cell Disease or Trait?	☐	☐
AIDS or HIV Infection?	☐	☐
Problems with Immune System?	☐	☐
Diabetes?	☐	☐
Prostate Trouble?	☐	☐
Artificial Joint?	☐	☐
Kidney Problems?	☐	☐
Dialysis?	☐	☐
Thyroid Trouble?	☐	☐
Ulcers?	☐	☐
Hepatitis?	☐	☐
Bleeding Trouble/Hemophilia?..	☐	☐
Neck or Back Trouble?.....	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	YES	NO
Chemotherapy?.....		
Radiation Treatments?.....		
Sinus Trouble?		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	YES	NO
Trouble with Jaw Joints?		
Hormone Treatments?		
Other Unlisted Disease?		

C. MEDICATIONS

Are you currently taking.....	YES	NO
Anticoagulants?		
Tranquilizers?		

	YES	NO
Cortisone?		
Any meds/pills for any purpose?		

Please list all medications:

Medication	Dosage	Medication	Dosage

D. ALLERGIES

Are you allergic to:	YES	NO
Penicillin?		
Other antibiotics?.....		
Sodium Pentothal/Valium/Tranquilizers		
Aspirin?		

	YES	NO
Codeine/Other Narcotics?.....		
Other Medications?		
Latex/Rubber Gloves?		
Other Allergies?		

Please list other allergies:

E. **Is there any condition concerning your health or family's anesthetic history that the doctor should be told?** *(If yes, explain)*: **YES / NO** _____

F. WOMEN:

Is there a possibility you may be pregnant?	YES	NO
Estimated Delivery Date?		

	YES	NO
Are you nursing?		
Are you taking birth control pills?		

***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 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 member of his/her staff responsible for any errors or omissions that I have made in completion of this form.

Signature of Patient/Guardian: _____ **Date:** _____

PATIENT – STOP HERE

PATIENT - DO NOT WRITE ON THIS PAGE

Date	Notes