

Welcome

Welcome

Welcome

WELCOME TO OUR PRACTICE

Date _____

PATIENT INFORMATION

1.1P

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

Referred By _____ Has a family member ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____ Orthodontist _____

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.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

1.10

Student: Full Time Part Time Not **School Info** _____

Married Divorced Legally Separated Widowed Single _____

Employed: Full Time Part Time Retired Not _____

Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY

1

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ **Plan** _____

Ins. Co. Name _____

Address _____

Group # _____ **Group Name** _____

Insured Party _____

Sex: M F Birth Date _____ S.S. # _____

Address _____

Tel. (_____) _____ **I.D. #** _____

1.11

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ **Plan** _____

Ins. Co. Name _____

Address _____

Group # _____ **Group Name** _____

Insured Party _____

Sex: M F Birth Date _____ S.S. # _____

Address _____

Tel. (_____) _____ **I.D. #** _____

SECONDARY DENTAL INSURANCE COMPANY

2

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ **Plan** _____

Ins. Co. Name _____

Address _____

Group # _____ **Group Name** _____

Insured Party _____

Sex: M F Birth Date _____ S.S. # _____

Address _____

Tel. (_____) _____ **I.D. #** _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ **Plan** _____

Ins. Co. Name _____

Address _____

Group # _____ **Group Name** _____

Insured Party _____

Sex: M F Birth Date _____ S.S. # _____

Address _____

Tel. (_____) _____ **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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 100. Have there been any changes in your general health in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 101. Are you under the care of a physician? Date of last visit _____
<i>If so, for what are you being treated?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 102. Have you had any illness, operation or been hospitalized in the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If so, describe</i> _____ | | |
| 103. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?..... <i>If so, describe where</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 104. Do you have a prosthetic joint/implant? <i>If so, describe where</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 105. Have you had a heart valve replacement or vascular graft? | <input type="checkbox"/> | <input type="checkbox"/> |

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	Pneumonia, 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? If so, # packs a day _____			
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	Cancer / 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	Have you, or a family member, had any unusual or serious reactions to general anesthesia?			

Please Note: All numbering is not sequential.

