PATIENT REGISTRATION FORM

FALLON ORAL SURGERY OF SYRACUSE
West Taft Medical Park, 4820 West Taft Rd, Liverpool, NY 13088

I. Patient Information

Marital Status ☐ Single ☐ Married Family Dentist: _____ Family Physician: _____

Title _____ Suffix _____ Sex: ☐M ☐F Date of Birth _____ Age: _____

Last _____ First _____ MI _____ Nickname _____

Address _____

_____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Social Security # _____ Driver's License: _____

II. Employment Information

Patient's Employer _____ Occupation: _____

Employer Address _____

City/State/Zip _____ Phone _____

Responsible Party Name _____

Responsible Party Employer _____ Occupation: _____

Employer Address _____

City/State/Zip _____

Phone _____ SS # _____

III. Insurance Information

PRIMARY: Insurance Type : ☒ Medical ☐ Dental **SECONDARY:** Insurance Type : ☐ Medical ☐ Dental

Subscriber	Name of Carrier	Subscriber	Name of Carrier
Group #	DOB	Group #	DOB
Agreement	Subscriber's SS #	Agreement	Subscriber's SS #
Plan	Policy #	Plan	Policy #

HEALTH QUESTIONNAIRE FORM

FALLON ORAL SURGERY OF SYRACUSE
West Taft Medical Park, 4820 West Taft Rd, Liverpool, NY 13088

I. General Information

Name: _____ Date: _____

Reason for today's office visit: _____

To Our Patients: Although oral surgeons 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 are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Yes No Are you in good health? Height: _____ Weight: _____

Yes No Have there been any changes in your general health in the past year?

Yes No Are you under the care of a physician? Date of last visit: _____
If YES, for what are you being treated? _____

Yes No Have you had any illness, operation, or been hospitalized in the past five years?
If YES please list: _____

Have you had or do you currently have …					Have you had or do you currently have …			
	YES	NO	NOTES			YES	NO	NOTES
Anemia					High Blood Pressure			
Anesthetic Problems (Family History)					History of Drug / Alcohol Abuse			
Arthritis					Infection			
Asthma					Irregular Heart Beat			
Bleeding Tendancy					Jaundice, Hepatitis, Liver Disease			
Blood Transfusion					Kidney Trouble			
Bronchitis, Chronic Cough					Low Blood Pressure			
Cancer					Low Blood Sugar			
Cardiac Pacemaker					Malignant Hyperthermia			
Chemotherapy or Radiation					Mental Health Problems			
Contact Lenses					Mitral Valve Prolapse			
Contagious Disease					Are you pregnant / nursing?			
Convulsions					*(estimated due date)*			
Delay in Healing					Problems with Immune System			
Diabetes					Prosthetic Knee / Hip etc.			
Dialysis					Removable Dental Appliance			
Difficulty Breathing					Rheumatic Fever			
Emphysema					Sexually Transmitted Diseases			
Epilepsy					Smoker			
Eye Disease					Sores in Mouth			
Fainting Spells					Stomach Ulcers			
Gallbladder Trouble					Stroke			
Hay Fever / Sinus Problems					Swollen Ankles			
Heart Attack/Chest Pain					Thyroid Trouble			
Heart Disease (Family History)					TMJ-Pain & Clicking of Jaws			
Heart Murmur/Artificial Valves					Tuberculosis			
Heart Surgery					Tumor or Growth			

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HEALTH QUESTIONNAIRE FORM

FALLON ORAL SURGERY OF SYRACUSE
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Name: _____ Date: _____

II. Allergy Information

	YES	NO	NOTES			YES	NO	NOTES
Local Anesthetic	☐	☐			Codeine or other Narcotics	☐	☐	
Penicillin	☐	☐			Other Medications	☐	☐	
Sodium Pentothal, Valium or	☐	☐			*(Please List)*			
other Tranquilizers					Allergies other than Drug Allergies	☐	☐	
Aspirin	☐	☐			Latex Allergy	☐	☐	
					Food Allergies	☐	☐	

III. Medication Information

	YES	NO				YES	NO	NOTES
Birth Control	☐	☐				☐	☐	
Anticoagulant (Blood Thinners)	☐	☐				☐	☐	

List all medications, drugs or pills:

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

☐ Yes ☐ No Is there any condition concerning your health that the Doctor should be made aware of?
If YES please explain:

☐ Yes ☐ No Is this visit related to an accident?
Type of Accident: ☐ Auto ☐ Work Related ☐ Other: _____
Date of Injury: _____ Insurance Company Handling Claim: _____
Name of Attorney / Adjuster: _____ Telephone #: _____

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 staff, responsible for errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature Date

CONSENT FOR USE & DISCLOSURE OF HEALTH INFO.

FALLON ORAL SURGERY OF SYRACUSE
West Taft Medical Park, 4820 West Taft Rd, Liverpool, NY 13088

Section A: Patient Giving Consent

Name:

Address:

Telephone: **Email:**

Patient Number: **Social Security Number:**

Section B: To the Patient - Please Read the Following Statements Carefully.

►**Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

►**Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Paul T., Timothy J. and Paul Casey Fallon
Telephone: (315) 451-6988
Fax: (315) 453-0150
Address: 4820 West Taft Road, Liverpool, NY 13088

►**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

►**Fees & Payments:** Although we accept payments from your insurance company toward your account, you are responsible for your full account. I am aware that they accept Master Card and Visa. **WE ARE A NON PARTICIPATING PROVIDER FOR ANY INSURANCE COMPANY.** I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. 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 GUARANTOR: **Date:**

►**Signature:** I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: **Date:**

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: **Relationship to Patient:**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

►**Revocation of Consent:** I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Witness Patient, Parent or Guardian Date

Witness Doctor

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

FALLON ORAL SURGERY OF SYRACUSE
West Taft Medical Park, 4820 West Taft Rd, Liverpool, NY 13088

Patient's Name Date

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

_____1. Swelling and/or bruising and discomfort in the surgery area.

_____2. Stretching of the corners of the mouth resulting in cracking or bruising.

_____3. Possible infection requiring additional treatment.

_____4. Dry socket - jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.

_____5. Possible damage to adjacent teeth, especially those with large fillings or caps.

_____6. Numbness, pain, or altered sensations in the teeth, gums, lip tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.

_____7. Trismus - limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.

_____8. Bleeding - significant bleeding is not common, but persistent oozing can be expected for several hours.

_____9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

_____10. Incomplete removal of tooth fragments - to avoid injury to vital structures such as nerves or sinus, sometimes small root tips may be left in place.

_____11. Sinus involvement - the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.

_____12. Jaw fracture - while quite rare, it is possible in difficult or deeply impacted teeth.

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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Teeth to be removed:_____

Alternative treatment: _____

_____

ANESTHESIA:

LOCAL ANESTHESIA: (Novocaine, Lidocaine, etc.) is given to block pain pathways in a localized area.

LOCAL ANESTHESIA WITH NITROUS OXIDE: Nitrous Oxide (or Laughing Gas) helps to decrease uncomfortable sensations and offers some degree of relaxation.

LOCAL INTRAVENOUS SEDATION OR GENERAL ANESTHESIA: alters your awareness of the procedure by producing sedative/amnesic effects, or sleep.

Whichever technique you choose, the administration of any medication involves certain risks. These include:

1. Nausea and vomiting.
2. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment.

In addition, there may be:

1. Pain, swelling, inflammation or infection of the area of the injection.
2. Injury to nerves or blood vessels in the area.
3. Disorientation, confusion, or prolonged drowsiness after surgery
4. Cardiovascular or respiratory responses which may lead to heart attack, stroke, or death.

Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. <u>If you have any questions, PLEASE ASK</u>.

I have read and understand the above and give my consent for:

… Local Anesthesia
… Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
… Local Anesthesia with Intravenous Sedation
… General Anesthesia

CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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CONSENT

I have read and understand the above and give my consent to surgery. I further state that if I have IV Sedation or General Anesthesia, that I HAVE NOT HAD ANY SOLIDS OR LIQUIDS BY MOUTH FOR **SIX (6) HOURS** PRIOR TO SURGERY. **TO DO OTHERWISE MAY BE LIFE-THREATENING!** I agree not to drive myself home and to have a responsible adult accompany me until I am recovered from my medications. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

TREATMENT / PROGRESS NOTES

FALLON ORAL SURGERY OF SYRACUSE
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Name :

DATE	TREATMENT / PROGRESS