Oral & Maxillofacial Surgery Associates **Chart #**

PATIENT INFORMATION: Date 01/10/2022

First Name_____ M.I. _____ Last Name_____

Sex____ Birthdate _____ Age_____ SS# _____ Email _____

Address_____City_____State_____Zip_____

Home #_____ Cell #_____ Work #_____

Preferred Contact # ☐ Home ☐ Cell ☐ Work May we leave a detailed message at this number? ☐ Yes ☐ No

Marital Status _____ Spouse's Name_____

Referred by_____ Primary Dentist_____ Primary Physician_____

Who will be responsible for your account?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

(If self, skip to next section)

First Name_____ M.I. ____ Last Name_____ SS#_____

Birthdate_____ Home # _____ Cell #_____

Address _____City_____State_____Zip_____

Employer _____ Business Telephone_____

Spouse or other Guarantor (if different from above)

First Name_____ M.I. ____ Last Name_____ Relation _____

Birthdate_____ Home # _____ Cell #_____ SS#_____

Address _____City_____State_____Zip_____

Employer _____ Business Telephone_____

INSURANCE INFORMATION:

Student: ☐ Full-time ☐ Part-time ☐ Not School Name _____

Marital Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

Employed: ☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employer Name_____

Primary Dental Insurance Company_____ Contract #_____

Name of Subscriber _____ Birthdate _____ Group #_____

Secondary Dental Insurance Company_____ Contract #_____

Name of Subscriber _____ Birthdate _____ Group #_____

Primary Medical Insurance Company_____ Contract #_____

Name of Subscriber _____ Birthdate _____ Group #_____

Secondary Medical Insurance Company_____ Contract #_____

Name of Subscriber _____ Birthdate _____ Group #_____

PLEASE ALLOW US TO COPY ALL OF YOUR INSURANCE CARDS **REV 6/19**

OTHER INFORMATION:

Why are you here today? _____

Have you ever been treated in this office before? _____

Have any family members been treated in this office? _____

If so, please name _____

Did your dentist send any information or X-ray? _____

Is this visit related to an accident? Automobile ☐ Yes ☐ No Work Related ☐ Yes ☐ No Other ☐ Yes ☐ No

Date of injury _____ Claim Number _____

Insurance Company handling this claim _____

Contact _____ Telephone _____

EMERGENCY INFORMATION:

Name _____ Telephone _____

Name of Nearest Relative Not Living with you:

Name _____ Telephone _____

Authorization, Fees and Payment

I understand that I am financially responsible for charges incurred during the course of my treatment. I also understand that I will be responsible for co-payments and deductibles as designated by my insurance company at the time of my visit. I, the undersigned, accept the fee as a lawful debt. In the event of default and the account is placed with a collection agency I agree to pay said fee, including any/all collection agency fees (33.33%), including attorney's fees and/or court costs, if such be necessary. Certain insurance carriers require a referral from the designated primary care doctor prior to seeing a specialist. In the event that a referral is not approved, the patient will be responsible for all charges. I understand that charges rejected as non-covered are the responsibility of the patient. I authorize the release of information necessary to process insurance claims and I assign payment of all insurance benefits relating to the treatment rendered to Oral and Maxillofacial Surgery Associates.

I certify that all the information given is correct.

_____

Signature of Patient / Guardian Date

Telephone Consumer Protection Act

You agree in order for us to service your account or to collect monies you may owe, Oral and Maxillofacial Surgery Associates and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers which could result in charges to you. We may also contact you by sending text message or emails using any email address you provide to us. Methods of contact may including using prerecorded/ artificial voice message and/or use of automatic dialing device as applicable.

_____

Signature of Patient / Guardian Date

ORAL & MAXILLOFACIAL SURGERY ASSOCIATES

Medical History

(Please Circle YES or NO)

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications 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.

Health History:

1. Height_____ Weight_____ Are you in good health?..... YES NO
2. Have there been any changes in your general health in the past year?..... YES NO
3. Are you under the care of a physician?..... Date of last visit_____ YES NO
   If so, for what are you being treated? _____
4. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?..... YES NO
5. Do you have a prosthetic joint/implant? ……If so, describe where_____ YES NO
6. Have you had a heart valve replacement or vascular graft? ……. YES NO
7. Have you ever had general anesthesia?..... YES NO
8. Have you, or a family member, had any unusual or serious reactions to general anesthesia?..... YES NO
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... YES NO
10. Do you wish to speak to the Dr. privately about anything?..... YES NO

Have you had, or do you currently have:

Heart Disease or Failure	YES	NO	Asthma	YES	NO
Heart Attack	YES	NO	Emphysema or Bronchitis	YES	NO
Chest Pain or Angina	YES	NO	Pneumonia	YES	NO
Irregular Heartbeat	YES	NO	Tuberculosis	YES	NO
Rheumatic Fever	YES	NO	Diabetes	YES	NO
Heart Murmur	YES	NO	Hiatal Hernia	YES	NO
High Blood Pressure	YES	NO	Stomach Ulcer	YES	NO
Anemia	YES	NO	Glaucoma	YES	NO
Bleeding Problems	YES	NO	Sickle Cell Disease	YES	NO
Take Blood Thinners	YES	NO	Unplanned Weight Loss	YES	NO
Kidney Disease	YES	NO	Risk Factors for AIDS/HIV	YES	NO
Thyroid Disease	YES	NO	Sexually Transmitted Diseases	YES	NO
Seizure Disorder	YES	NO	Cancer	YES	NO
Hepatitis or Liver Disease	YES	NO	Arthritis	YES	NO
Steroid Therapy	YES	NO	Alcohol or Drug Abuse	YES	NO
Stroke	YES	NO	Blood Transfusion in past	YES	NO
Mental Disorders	YES	NO	Do you wear Contacts	YES	NO
Sleep Disorder	YES	NO	Problems with Anesthesia	YES	NO
Jaw Joint Problems	YES	NO	Osteoporosis	YES	NO
Contagious Diseases	YES	NO	Osteonecrosis	YES	NO
Cardiac Pacemaker	YES	NO	Bruise easily	YES	NO
Hay fever / sinus problems	YES	NO	Infectious mononucleosis	YES	NO
Difficult breathing / other lung trouble	YES	NO	Gallbladder trouble	YES	NO
Fainting spells	YES	NO	Low blood sugar	YES	NO
High cholesterol	YES	NO	Are you on dialysis	YES	NO
Problems with immune system	YES	NO	Delay in healing	YES	NO
A tumor or growth	YES	NO	Chronic fatigue / night sweats	YES	NO
Are you on a diet	YES	NO	A removable dental appliance	YES	NO
Any allergies	YES	NO			

If you Circles “YES” to any of the above, please give further information in the space below:

Surgical History: Have you ever had surgery? If so, please list all prior surgeries. YES NO

Surgery_____Date_____Complications_____

Surgery_____Date_____Complications_____

Surgery_____Date_____Complications_____

Social History:

Do you smoke cigarettes, use tobacco products, vape, or have you used them?..... YES NO
If so, how much per day_____ For how long_____ If you quit, when_____

Do you drink caffeine?..... YES NO
If so, how many cups per day_____

Do you drink alcohol?..... YES NO
If so, how often_____

Do you use any recreational drugs / substances?..... YES NO

Are you now taking?

Any kind of medication, drug, pills? YES NO

Have you ever taken diet pills? YES NO

Any natural product, herbal supplement, or homeopathic remedy? YES NO

Are you taking, or have your ever taken, bone density meds or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Xgeva, Prolia, or Reclast in the past 12 years? YES NO

Please list any medications taken on a regular basis:

ALLERGIES:

Women Only:

Is there a possibility of pregnancy? YES NO Expected delivery date? _____

Are you nursing? YES NO Last Menstrual Period? _____

Are you taking birth control pills? YES NO

A. IF YOU ARE USING ORAL CONTRACEPTIVES IT IS IMPORTANT THAT YOU UNDERSTAND THAT ANTIBIOTICS AND OTHER MEDICATIONS MAY INTERFERE WITH EFFECTIVENESS OF ORAL CONTRACAPTIVES. THEREFORE, YOU WILL NEED TO USE MECHANICAL FORMS OF BIRTH CONTROL FOR ONE COMPLETE CYCLE OF BIRTH CONTROL PILLS AFTER THE COURSE OF ANTIBIOTICS OR OTHER MEDICATIONS IS COMPLETED. PLEASE CONSULT WITH YOUR PHYSICIAN FOR FUTHER GUIDANCE.

B. IF YOU ARE PREGNANT, POSSIBLY PREGNANT OR TRYING TO BECOME PREGNANT, SURGERY, ANESTHETICS OR ANY OTHER MEDICATION MAY SIGNIFICANTLY HARM YOUR DEVELOPING BABY, ESPECIALLY DURING THE FIRST TRIMESTER. PLEASE ADVISE YOUR DOCTOR IF THERE IS NAY CHANCE OF YOUR BEING PREGNANT.

Personal health information provided in this Medical History is confidential. It is intended for the use of Oral and Maxillofacial Surgery Associates and may be released to other parties in accordance with the terms of the authorization that you have signed, including as necessary to allow processing of insurance claims, or as allowed by state or federal law. The information provided in this form is accurate and complete.

Signature_____ **Date** _____ _____

(Parent or legal guardian if minor) (Signature of Doctor)

Oral and Maxillofacial Surgery Associates Medical Release Form

Due to federal guidelines under HIPAA, we are now required to have a release form signed by the patient before we can give out any medical information to any person other than the patient.

Please list below the names, relationships, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc) that we may discuss your medical or financial information with.

Name	Relationship	Phone Number
1.		
2.		
3.		

May we leave medical information on your home answering machine or cell phone voice mail? Yes ____ No ____

May we confirm your appointment on your home answering machine or cell phone voice mail? Yes ____ No ____

_____

Signature of Patient or Legal guardian Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign below.

_____

Signature of Patient or Legal guardian Date

The above information is private and confidential and will be placed in your patient file. The information on this form will remain valid until we are notified otherwise.

I acknowledge that I have read (or had the opportunity to receive) a copy of Oral and Maxillofacial Surgery Associates **Notice of Privacy Practices**.

_____

Signature of Patient or Legal guardian Date

Rev 4/17

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled in advance. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

Appointments will need to be cancelled by noon (12pm) 2 days prior to the scheduled appointment. Monday and Tuesday appointments will need to be cancelled Friday by noon. If an appointment is not cancelled in advance you may be subject to a $50.00 administrative fee.

Patients that miss their appointments are considered a no show and may also be subject to a $50.00 administrative fee.

The Cancellation and No Show fees are the responsibility of the patient and must be paid in full to reschedule an appointment.

Our practice believes that good physician/patient relationship is based upon understanding and good communication. Thank you for being a valued patient. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients

Please sign that you have read, understand and agree to this Cancellation and No Show Policy

_____

Signature Patient/Guardian Date

REV12/18