Auburn Oral Surgery and Implant Center

PATIENT INFORMATION

Title: (Mr., Mrs., Ms., Dr.) First Name_____ M.I. _____ Last Name_____

Sex: ☐ Male ☐ Female Date of Birth_____ Age _____ Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Tel.# ( ) _____ Cell/Work Tel.# ( ) _____ Ext _____

Dentist _____ Physician _____ Referred By _____

Student: Full Time ☐ Part Time ☐ Not ☐ School Name/State_____

Married ☐ Divorced ☐ Legally Separated ☐ Widow ☐ Single ☐

Employed: Full Time ☐ Part Time ☐ Retired ☐ Email Address: _____

IN CASE OF EMERGENCY

Name _____ Tel.# ( ) _____

Street _____ City _____ State _____ Zip _____

GUARANTOR (if patient is a minor)

Title: (Mr., Mrs., Ms., Dr.) First Name_____ M.I. _____ Last Name_____

Street _____ City _____ State _____ Zip _____

Home Tel.# ( ) _____ Work Tel.# ( ) _____ Ext _____

Social Security #_____ Relationship to patient_____ D.O.B._____

PATIENT'S DENTAL INSURANCE CO.

Insurance Co.:_____

Address _____

_____

Tel.# ( ) _____

Group # _____ ID # _____

DENTAL INS. POLICY HOLDER NAME

Name of Policy Holder _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Sex: ☐ Male ☐ Female Date of Birth _____

Street _____

City _____ State _____ Zip _____

Tel.# ( ) _____ S.S. # _____

DENTAL INS. POLICY HOLDER'S EMPLOYMENT INFORMATION (Parent or Guardian if patient is minor)

Employer's Name _____ Tel.# ( ) _____

Street _____ City _____ State _____ Zip _____

PATIENT'S MEDICAL INSURANCE CO.

Insurance Co.:_____

Address _____

_____

Tel.# ( ) _____

Group # _____ ID # _____

MEDICAL INS. POLICY HOLDER NAME

Name of Policy Holder _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Sex: ☐ Male ☐ Female Date of Birth _____

Street _____

City _____ State _____ Zip _____

Tel.# ( ) _____ S.S. # _____

MEDICAL INS. POLICY HOLDER'S EMPLOYMENT INFORMATION (if different from above)

Employer's Name _____ Tel.# ( ) _____

Street _____ City _____ State _____ Zip _____

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
1.	Are you in good health? _____ Height _____ Weight _____	❑	❑
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 had any illness, operation or been hospitalized in the past five years? _____ _____	❑	❑
5.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where _____	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
6	Do you have a prosthetic joint?			
7	Rheumatic fever?			
8	Damaged heart valves / mitral valve prolapse?			
9	Heart murmur?			
10	High blood pressure?			
11	Low blood pressure?			
12	Chest pain, angina?			
13	Heart valve replaced?			
14	Heart attack(s)?			
15	Irregular heart beat?			
16	Cardiac pacemaker?			
17	Heart surgery?			
18	Bronchitis, chronic cough?			
19	Asthma?			
20	Hayfever / Sinus problems?			
21	Sleep Apnea?			
22	Emphysema?			
23	Difficult breathing / other lung trouble?			
24	Do you smoke? How much?			
25	Have you had a history of smoking?			
26	Do you smoke Marijuana ?			
27	Blood disorder such as anemia?			
28	Bruise easily / Blood Transfusion?			
29	Bleeding tendency (abnormal bleed)?			
30	Jaundice, hepatitis or liver disease?			
31	Fainting spells?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
32	Convulsions, epilepsy?			
33	Stroke?			
34	Thyroid trouble?			
35	Diabetes?			
36	Low blood sugar?			
37	Kidney trouble?			
38	Are you on dialysis?			
39	Swollen ankles, arthritis or joint disease?			
40	Stomach ulcers?			
41	Contagious diseases?			
42	Sexually transmitted diseases?			
43	Do you have any reason to be immunosuppressed?			
44	Delay in healing?			
45	A tumor or growth?			
46	Radiation treatment/chemotherapy?			
47	Chronic fatigue / night sweats?			
48	Are you on a diet?			
49	A history of drug abuse?			
50	A history of alcohol abuse?			
51	Eye disease / glaucoma?			
52	Mental health problems?			
53	A removable dental appliance?			
54	Pain & Clicking of jaws when eating?			
55	Malignant Hyperthermia?			
56	Any family history of anesthetic problems?			

MEDICATION							
ARE YOU NOW TAKING...	YES	NO	NOTES	ARE YOU NOW TAKING...	YES	NO	NOTES
1. Any kind of medicine, drugs, or pills?				4. Cortisone?			
2. Anticoagulants/Blood thinners?				5. Other medications (please list)			
3. Tranquilizers?				6. Bone density meds.?			

ALLERGIES							
ARE YOU ALLERGIC TO OR HAD A REACTION TO...	YES	NO	NOTES	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	YES	NO	NOTES
6. Local Anesthetics?				10. Aspirin?			
7. Penicillin?				11. Codeine or other narcotics?			
8. Other antibiotics?				12. Other medications?			
9. Sodium pentothal, valium, or other tranquilizers?				13. Allergies other than drug allergies (Please List)			

History of taking Bisphosphonates: (Fosamax, Boniva, Zometa)? Yes ☐ No ☐

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes ☐ No ☐ _____

WOMEN							
	YES	NO	NOTES		YES	NO	NOTES
14. Is there a possibility of pregnancy?				16. Are you nursing?			
15. Estimated delivery date? ____/____/____				17. 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.

Additional Information: _____

_____

_____

_____

_____

_____

_____

_____

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

SIGNATURE OF PATIENT_____ **DATE** _____

(Parent or Guardian if Minor)

Financial Obligation

I understand and acknowledge that <u>I AM PERSONALLY FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED FOR MYSELF, OR THE ABOVE NAMED, REGARDLESS OF INSURANCE COVERAGE. FULL PAYMENT/CO-PAYMENT IS DUE AT THE TIME OF SERVICE,</u> unless prior arrangements have been made with the office manager. <u>UPON MY FAILURE TO PAY ANY AMOUNT WHEN DUE. I AGREE TO PAY ALL COSTS OR EXPENSES INCURRED IN THE COLLECTION OF SUCH AMOUNT DUE, INCLUDING COURT COSTS.</u> 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 PATIENT_____ **DATE** _____

(Parent or Guardian if Minor)

Progress Notes

DATE	NOTES