

Welcome to our Practice

PATIENT INFORMATION:

Today's Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No
Referred By FIRST NAME _____ LAST NAME _____ Has a family member ever been a patient of our practice? Yes No
Dentist FIRST NAME _____ LAST NAME _____ Orthodontist FIRST NAME _____ LAST NAME _____ Medical Dr. FIRST NAME _____ LAST NAME _____
Driver's Lic. # _____ Nearest relative not living with you FIRST NAME _____ LAST NAME _____ Tel. (_____) _____
Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Self (If self, skip this section) Spouse Father Mother Other _____
Name FIRST NAME _____ LAST NAME _____ S.S. # _____ Birth Date _____ Age _____
Tel. (_____) _____ Cell. (_____) _____ E-mail _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Driver's Lic. # _____ Employer _____ Bus. Tel. (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name FIRST NAME _____ LAST NAME _____ Relation _____ S.S. # _____ Birth Date _____
Street _____ Apt. _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION:

Student: Full Time Part Time Not School Name and Address SCHOOL NAME _____ ADDRESS _____
Marital Status: Married Divorced Widow Single Legally Separated CITY _____ STATE _____ ZIP _____
Employed: Full Time Part Time Retired Not Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____
Bus. Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____
Bus. Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Bus. Tel. (_____) _____ Plan _____
Ins. Co. Name _____ I.D. # _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____
Tel. (_____) _____ Group Name _____
Group # _____ Insured Party FIRST NAME _____ LAST NAME _____
Relation _____ Birth Date _____ Sex: M F
S.S. # _____ Tel. (_____) _____
Address ADDRESS _____ CITY _____ STATE _____ ZIP _____



**SOUTHEAST
ORAL & MAXILLOFACIAL
SURGERY ASSOCIATES**

To Our Patients: Although oral surgeons primarily treat the area in and around the mouth, your mouth is 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.

Name _____ DOB _____

	Yes	No	Notes
1. Height _____ Weight _____ Are you in good Health?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have there been any changes in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you under the care of a physician? Date of last visit _____ Name of Physician _____ Phone # _____	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you had any illness, operation or been hospitalized in the past few years? If so, describe _____	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you had a upper respiratory infection in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you have a prosthetic joint or implant? If so, where? _____	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had a heart valve replacement or vascular graft?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you or a family member, had unusual or serious reaction to anesthesia? If so, describe _____	<input type="checkbox"/>	<input type="checkbox"/>	
9. Has a physician recommended that you take antibiotics prior to dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Damaged heart valves/mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	
13. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Chest pain/angina?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Heart attack(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Cardiac pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Pneumonia, bronchitis, chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	
21. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Hay fever/sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Snoring/sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Difficult breathing/other lung trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
25. Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Do you smoke? If so, number of packs a day _____	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Notes
28. Do you use chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	
29. Blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	
30. Blood disorder such as anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
31. Bruise easily?	<input type="checkbox"/>	<input type="checkbox"/>	
32. Bleeding tendency/disorder (eg. Hemophilia)	<input type="checkbox"/>	<input type="checkbox"/>	
33. Hepatitis, jaundice, or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	
34. Infectious mononucleosis?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	
36. Convulsions/Seizures ?	<input type="checkbox"/>	<input type="checkbox"/>	
37. A removable dental appliance?	<input type="checkbox"/>	<input type="checkbox"/>	
38. Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	
39. Thyroid trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
40. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
41. Low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	
42. Kidney trouble?	<input type="checkbox"/>	<input type="checkbox"/>	
43. Are you on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	
44. Swollen ankles/arthritis/joint disease?	<input type="checkbox"/>	<input type="checkbox"/>	
45. Osteoporosis/osteopenia?	<input type="checkbox"/>	<input type="checkbox"/>	
46. Osteonecrosis?	<input type="checkbox"/>	<input type="checkbox"/>	
47. Pain or clicking of jaws when eating?	<input type="checkbox"/>	<input type="checkbox"/>	
48. Contagious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
49. Sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
50. Are you immunosuppressed? Possibly from transplant surgery, medication, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
51. Problems with immune system? Possibly from HIV, AIDS, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
52. Delay in healing?	<input type="checkbox"/>	<input type="checkbox"/>	
53. A tumor or growth?	<input type="checkbox"/>	<input type="checkbox"/>	
54. Cancer/radiation therapy/chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	
55. Chronic fatigue/night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	
56. Are you on a diet?	<input type="checkbox"/>	<input type="checkbox"/>	
57. A history of alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
58. A history of drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
59. Contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
60. Eye disease/glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>	
61. Mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	



Name _____ DOB _____

Women Only (Questions)	Yes	No	Notes
62. Is there a possibility of Pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	
63. Expected delivery date? _____	<input type="checkbox"/>	<input type="checkbox"/>	
64. Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
65. Are you taking birth control pills or other form of birth control (Depo shot, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	

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

Is there a family history of:	Yes	No	Notes
66. Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
67. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
68. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
69. Anesthesia problems?	<input type="checkbox"/>	<input type="checkbox"/>	

Are you allergic to:	Yes	No	Notes
70. Latex?	<input type="checkbox"/>	<input type="checkbox"/>	
71. Eggs/Egg yolk?	<input type="checkbox"/>	<input type="checkbox"/>	
72. Soy?	<input type="checkbox"/>	<input type="checkbox"/>	
73. Sulfites?	<input type="checkbox"/>	<input type="checkbox"/>	

74. Have you taken corticosteroids in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
75. Are you taking any bone density medications/bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Reclast, Boniva)?	<input type="checkbox"/>	<input type="checkbox"/>	
76. Is there any condition concerning your health that the Doctor should be told about? If yes describe. _____	<input type="checkbox"/>	<input type="checkbox"/>	

Please list all medications (including natural products) that you are taking:		
Medication	Dosage	Frequency

Please list all known allergies (medication, anesthetic, food, etc.)	

AUTHORIZATION

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X _____ X _____ X _____ X _____
 Signature of patient (Parent or Guardian in Minor) Witness Doctor Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____
 Signature of patient (Parent or Guardian in Minor) Date

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. We are not required by law to agree to this restriction, but if we do, we shall honor that agreement to the best of our ability.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has had the opportunity to review (or decline review of) this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to request restriction of the use of their information but the Practice is not required by law to agree to those restrictions.

Print Patient Name

Date

Signature (Patient must sign form unless under the age of 18)

If there is anyone else that you would like to have access to your medical treatment plan or financial records please list their name(s) and relationship to you. Unless a patient is under the legal age of 18, disclosure of private health information may be communicated ONLY with the patient unless permission to do so is granted in writing prior to request.

Name and relationship to patient

Name and relationship to patient

PLEASE READ & SIGN BEFORE SEEING THE DOCTOR

We are NOT considered In-Network providers with ANY DENTAL INSURANCE PLANS. We will gladly submit your claims for you but we do not take ANY negotiated adjustments. Please note that you may be subject to a lower benefit level when receiving out of network care or in some rare cases, have no coverage at all.

Our Doctors are considered In-Network Providers for the following MEDICAL INSURANCE PLANS:

**AETNA
BLUE CROSS BLUE SHIELD
CIGNA
COVENTRY/WELLPATH
HEALTHCARE SAVINGS
UNITED HEALTHCARE**

If your insurance company is not listed above please ask to speak to someone in our insurance department if you have any questions.

****Delta Dental patients are expected to pay in full for all services rendered if the service is not covered by another insurance. Delta Dental reimburses their subscribers directly.****

signature_____date_____