Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT INFORMATION **Today's Date:**

First Name _____ M.I. _____ Last Name _____

Nickname _____ Dentist _____ Referring Doctor _____

Mailing address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Can we call your cell phone to discuss insurance or financial questions? Y / N

Birth Date _____/_____/_____ Sex: M / F / Unspecified Social Security number _____

Marital status: Married / Single / Widowed / Divorced Has a family member been a patient of our practice? Y / N

Employer / School _____ Fulltime / Part time Work Phone ( ) _____

Email _____

Emergency contact _____ Relationship _____ Phone ( ) _____

PERSON RESPONSIBLE FOR PAYMENT

☐ Self (if self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

First Name _____ Last Name _____ Nickname _____

Mailing address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Birth Date _____/_____/_____ Sex: M / F / Unspecified Social Security number _____

Marital Status _____ Email _____

INSURANCE – PLEASE PROVIDE CARD(S) AT FRONT DESK ***Please skip this section if the **patient** is the policy holder***

Dental Insurance: _____

Policy holder name: _____

Relationship to patient: _____

Birth date: _____/_____/_____

Social Security number _____

Mailing address: _____

_____

Medical Insurance: _____

Policy holder name: _____

Relationship to patient: _____

Birth date: _____/_____/_____

Social Security number _____

Mailing address: _____

_____

For patients 18 years old and over:

I authorize you to speak to: _____ *Relationship:* _____

I authorize you to speak to: _____ *Relationship:* _____

To the best of my knowledge, the information given is true and correct.

_____ _____

Date **Patient / Legal Guardian Signature**

Williams Oral & Maxillofacial Surgery, Prof LLC.

HEALTH HISTORY

Patient Name _____ Birth Date ____/____/____ Age _____ Today's Date _____

Please complete the health history so that we may provide the best possible care; the doctor will discuss the history with you prior to beginning treatment.

GENERAL INFORMATION

Sex: M / F / Unspecified Height _____ Weight _____ Are you in good health? Y / N

Reason for today's office visit? _____

Are you now under a physician's care for a particular problem? If so, describe: _____

_____

Physician name and telephone # _____ Date of last physical exam _____

Has there been any change in your general health in the past year? If so, describe: _____

_____

Have you ever had any serious illness? If so, describe: _____

_____

Have you ever been hospitalized or had any surgery or anesthesia? If so, describe: _____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y / N

A) PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Can you take pills?
2. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
3. Do you grind or clench your teeth?
4. Have you had any serious problems associated with previous dental treatment?
5. Have you or an immediate family member had any problem associated with anesthesia?
6. Do you smoke or chew tobacco?
   How much? _____
   For how long? _____
7. When did you last smoke? _____
8. Is there any past history of alcohol or chemical dependency?
9. Is there any emotional or psychiatric illness that may affect the care we provide?
10. Do you wish to talk to the doctor privately about anything?

B) FOR FEMALE PATIENTS ONLY

1. Are you pregnant, or is there any chance you might be pregnant? _____ How many weeks along? _____
2. Are you nursing?_____

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

Williams Oral & Maxillofacial Surgery, Prof LLC.

C) DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High blood pressure?
3. Stroke?
4. Heart surgery? (bypass or stent)
5. Pacemaker?
6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy, seizures, or brain injury?
8. Fainting or dizziness?
9. Bleeding disorder, anemia?
10. Blood transfusion?
11. Bruise or bleed easily?
12. Liver disease? (jaundice, hepatitis)
13. Kidney disease?
14. Diabetes?
15. Thyroid disease?
16. Arthritis?
17. Stomach ulcers or acid reflux? (GERD)
18. Other GI disease?
19. Glaucoma?
20. Osteoporosis?
21. Implants or joint replacements?
22. Cancer?
23. Radiation therapy?
24. Chemotherapy?
25. Sinus or nasal problems?
26. Seasonal allergies?
27. Snoring or sleep apnea?
28. Fibromyalgia?
29. Psychiatric illness or mood disorder?
30. Disease or medication that has depressed your immune system?
31. Organ transplant?
32. Delay in healing?
33. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

D) ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia (Novocain, etc.)?
2. Penicillin?
3. Other antibiotics?
4. Sedatives, barbiturates?
5. Aspirin?
6. Ibuprofen?
7. Codeine or other pain killers?
8. Latex or rubber products?
9. Chemicals or jewelry (rash or sensitivity)?
10. Food products? Soy? Eggs?
11. Other allergies or reactions? If so, please list:

_____

_____

E) ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners (Coumadin, Plavix, etc.)?
3. Aspirin or ibuprofen?
4. Steroids (cortisone, prednisone, etc.)?
5. Tranquilizers, sleep aids, antidepressants, narcotics?
6. Insulin or oral anti-diabetic drugs?
7. Have you ever been advised to **not** take a medication?
8. **Have you ever taken** bisophosphonates, antiangiogenic, antiresorptive bone density medications? (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Avastin, Sutent)
9. **Other Medications:**

_____

_____

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

_____

Date **Patient / Legal Guardian Signature**

Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT NAME: _____

Financial Responsibility

I understand and agree to the following:

- I am responsible for any and all charges on this account.
- **Full payment is due on the day of service, unless prior arrangements have been made.**
- **Insurance**:
    - Sedation/anesthesia services are **NOT** covered by insurance for simple, uncomplicated tooth extractions.
    - **Any payment made by me is only a down-payment.** My insurance payment may be significantly less than the remaining balance on my account.
    - **I understand that I am responsible for any and all charges not covered by my insurance**, *including those charges for anesthesia/sedation*.
    - I authorize direct payment to Williams Oral and Maxillofacial Surgery Prof LLC by my insurance company. A copy of this original may be used in place of the original.
- Account balances more than 60 days old will be assessed a late fee of $25.00 per month, every month, until the account is paid in full. Alternatively, a collection agency may be utilized.

Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices

I have read this office's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

(You may refuse to sign this section – please initial if you wish to refuse _____)