WELCOME TO OUR PRACTICE

Office use only: Patient's ID# _____

PATIENT INFORMATION

Prefix_____ First Name _____ M.I. ____ Last Name _____

Address _____ Apt ____ City _____ State _____ Zip _____

Patient Sex: ☐ Male ☐ Female Date of Birth: _____/____/_____ Age _____ Social Security # _____ - _____ - _____

Driver's license # _____ Employer _____

CONTACT INFORMATION

Home # (_____)_____

Cell # (_____)_____

Work # (_____)_____

Preferred #: Home / Cell / Work

E-mail:

_____

DOCTOR INFORMATION

Dentist: Dr._____

Medical: Dr. _____

Orthodontist: Dr: _____

CONTACT IN CASE OF EMERGENCY

1. Name: _____
   Telephone (_____)_____
   Relation _____

2. Name: _____
   Telephone (_____)_____
   Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT?

☐ Self (If self, skip this section)

☐ Father ☐ Mother ☐ Spouse ☐ Other _____

*** If you are 18 years of age, you are the financially responsible party**

*** For children under the age of 18, the parent who accompanies the child to appointment will be listed as financially responsible for the child regardless of who holds the insurance.**

Prefix_____ First Name _____ Last Name _____

Address _____ Apt ____ City _____ State _____ Zip _____

Tel. (_____)_____ Cell. (_____)_____ E-mail _____

Date of Birth: _____/____/_____ Age _____ Social Security # _____ - _____ - _____

PRIMARY DENTAL INSURANCE INFORMATION

Please provide mailing address for insurance ONLY if card is not available to scan at appt.

Employer _____

Ins. Co. Name _____ Address_____

ID# _____ Group# _____

Insured Party: _____ _____
FIRST NAME LAST NAME

Relation: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Address of insured party (if different from patient):

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

PRIMARY MEDICAL INSURANCE INFORMATION

Please provide mailing address for insurance ONLY if card is not available to scan at appt.

Employer _____

Ins. Co. Name _____ Address_____

ID# _____ Group# _____

Insured Party: _____ _____
FIRST NAME LAST NAME

Relation: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Address of insured party (if different from patient):

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

SECONDARY DENTAL INSURANCE INFORMATION

Please provide mailing address for insurance ONLY if card is not available to scan at appt.

Employer _____

Ins. Co. Name _____ Address_____

ID# _____ Group# _____

Insured Party: _____ _____
FIRST NAME LAST NAME

Relation: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Address of insured party (if different from patient):

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

SECONDARY MEDICAL INSURANCE INFORMATION

Please provide mailing address for insurance ONLY if card is not available to scan at appt.

Employer _____

Ins. Co. Name _____ Address_____

ID# _____ Group# _____

Insured Party: _____ _____
FIRST NAME LAST NAME

Relation: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Address of insured party (if different from patient):

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

HEALTH HISTORY

Office use only: Patient's ID# _____

To our patients: *Oral and Maxillofacial surgeons are the experts in face, mouth and jaw surgery. The information you provide will help us to treat you best by taking into account your overall health. Thank you for answering the following questions. This information will be kept confidential.*

Patient Name _____ Height _____ Weight _____ Birth Date: _____

- **Have there been any changes in your general health in the past year? ..... ☐ YES ☐ NO**
  If so, describe _____
- **Have you had any illness, operation or been hospitalized in the past 5 years? ..... ☐ YES ☐ NO**
  If so, describe _____
- **Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ..... ☐ YES ☐ NO**

MEDICATIONS: Are you taking any of the following medications?

- ☐ I am not taking medication/drugs/pills
- ☐ Anticoagulants (Blood Thinners)
- ☐ Heart medications
- ☐ Steroids (Cortisone, Prednisone, etc.)
- ☐ Anti-anxiety / Anti-depressants / Other psychiatric medications
- ☐ Aspirin, Motrin, Aleve, Ibuprofen
- ☐ Insulin or anti-diabetic drugs
- ☐ Blood pressure medications

List the name of all the medications you are currently taking OR bring a list of medications to your appointment and we can scan a copy for your chart.

Medication list	Medication list continued

Have you taken bisphosphonates, medications to strengthen your bones, IV medications, or other cancer drugs? ☐ **YES** ☐ **NO**
If yes, list drugs used and time of use _____

Any cancer, radiation, or chemotherapy? ☐ **YES** ☐ **NO** Describe**:** _____ Date of last treatment? _____

ALLERGIES: Are you allergic to or have you had a bad reaction to any of the following?

- ☐ No known allergies
- ☐ Latex
- ☐ Food products (i.e. soy, eggs/yoke)
- ☐ Codeine or other pain killers
- ☐ Aspirin, Motrin, Aleve, or Ibuprofen
- ☐ Penicillin or other antibiotics
- ☐ Cinnamon, Thyme, Aloe or Clove
- ☐ Other drug or food allergies not listed?

_____
_____

Have you had problems associated with local anesthesia, general anesthesia, and/or intravenous sedation?
☐ **YES** ☐ **NO**
If yes, which anesthetic? _____

MEDICAL HISTORY: Have you had, or do you currently have any of the following?

	YES	NO		YES	NO		YES	NO
Bleeding Disorder?			Stroke?			Stomach Ulcers/Acid Reflux?		
Anemia?			High Blood Pressure?			Seizures or Epilepsy?		
Bleeding Tendency?			Low Blood Pressure?			Eye Disease/Glaucoma?		
Blood Transfusion?			Asthma?			Swelling Ankles / Arthritis / Joint Disease?		
Bruise Easily?			Lung Disease / Breathing Problems?			Mental Health problems / Anxiety / Depression?		
Congenital Heart Disease?			Emphysema?			Osteoporosis/Osteopenia?		
Heart Murmur?			Tuberculosis?			Osteonecrosis?		
Heart Attack(s)?			Diabetes?			HIV or AIDS?		
Irregular Heartbeat?			Kidney Disease?			Sleep Apnea / CPAP?		
Previous Heart Surgery?			Kidney failure requiring dialysis?			Removable dental appliance		
Cardiac Pacemaker?			Frequent or recurring mouth sore?			Pain or click of jaws when eating?		
Coronary Artery Disease?			Liver Disease / Jaundice / Hepatitis?			Significant weight loss or gain?		
Chest Pain / Angina?			Thyroid Disease?			Sinus or nasal problems?		
Damaged Heart Valve / Mitral Valve/Prolapse?			Pneumonia / Bronchitis / Chronic Cough?			Implant placed anywhere in body (heart valve, pacemaker, hip, knee)		

Do you have any other disease, condition or problem not listed above? ☐ **YES** ☐ **NO**
If yes, please explain: _____

FAMILY MEDICAL HISTORY

Malignant Hyperthermia? ☐ **YES** ☐ **NO**

Bleeding problems? ☐ **YES** ☐ **NO**

Any other significant family history you feel our office should know about? _____

SOCIAL HISTORY

Do you smoke, vape or chew tobacco? ☐ **YES** ☐ **NO** How often? _____

Do you use Marijuana? ☐ **YES** ☐ **NO**

Do you drink alcohol? ☐ **YES** ☐ **NO** How many drinks per week? _____

Do you use recreational drugs? ☐ **YES** ☐ **NO**

FEMALE PATIENTS HISTORY

Are you pregnant, or is there a chance you might be pregnant? ☐ **YES** ☐ **NO**

Are you nursing? ☐ **YES** ☐ **NO**

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I Certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____
Signature of patient (Parent or Guardian if minor) Date

AUTHORIZATION TO RELEASE INFORMATON TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Drs. Doran, Capodice, Efaw & Ocheltree, LLC to release my records and any information to the following individuals:

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

_____ **I DO NOT** give permission for my personal health information to be discussed with anyone other than myself

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 the examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment

X _____ **X** _____
Signature of patient (Parent or Guardian if minor) Date

Do you want a copy of The Notice of Privacy Practices?

_____ **YES**, I wish to receive a copy of the Notice of Privacy Practices _____ **NO**, I do not wish to receive a copy of the Notice of Privacy Practices.

* *You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us by phone or email*.

FINANCIAL AGREEMENT

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

We accept most insurance plans and submit claims to those plans on your behalf**. It is your responsibility to pay for all services provided that are not covered by your insurance. This might include any amount denied or not covered by your insurance plan or your co-pay.**

Any check returned for non-sufficient funds will be charged $25.00

Should your account become delinquent it will be assigned to a collection agency. You will be responsible for the costs incurred in collection of this balance, which includes a monthly 1% finance charge, collection agency fees of 35%, court costs and attorney fees.

X _____ **X** _____
Signature of patient (Parent or Guardian if minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I herby authorize payment to this doctor named of the benefits otherwise payable to me

X _____ **X** _____
Signature of patient (Parent or Guardian if minor) Date