

Welcome to our Practice



PATIENT INF	ORMATION:					Date:	
□Mr. □Mrs.	□Ms. □Dr.	First Name		M.I.	Last Name		
		1 110(11a1110					
Sex: ☐Male	□Female	Birth Date	Age	_ Soc.Sec.#			
Street				Apt	City	State	_Zip
5.	,		0 H Di				
			Cell Phone () Yes N Has a family membe				
navo you ovo	n boon a pation	torour produce.		r ovor boom a pation	it or our produces. — rec		
Referred By_	FIRST NAME		LAST NAME	Dentist		LAST NAME	
Orthodontist_	FIRST NAME		LAST NAME	Medical Dr	FIRST NAME		AST NAME
	TITOTIVAME		ENOT INNIE		TIKOTIVAWE		AOT MAINE
Driver's Licen	se #			_ Nearest relative n	ot living with you		
Employer						ME AND PHONE NUMBER	
			☐Credit Carc We accept: Visa, Ma				
						_	
In case of em	ergency				Phone	R	elation
WHO WILL B	E RESPONSIE	BLE FOR YOUR	ACCOUNT:				
□Colf /If colf	f akin this coati	on) Denouse	□Father □Mother □Other				
Goeii (ii seii	i, skip iilis seciil	on) — Spouse					
Name							
Sex: □Male	□Female	Birth Date	Age	Soc.Sec.#			
Street				_ Apt	City	State	_ Zip
Home Phone	()		Cell ()				
D : 1 1:	"					D DI ()	
Driver's Licen	se #		Employer			Bus. Phone ()	
SPOUSE OR	OTHER GUAR	ANTOR INFORM	MATION: (IF DIFFERENT FROM A	NBOVE)			
□Mr □Mre	□Me □Dr	Firet Name		MI	Last Namo		
GIVII. GIVII3.	alvis. udi.	i iist ivailie		IVI.I	Last Name		
Sex: ☐Male	□Female	Birth Date	Age	_ Soc.Sec.#			
Street				Apt	City	State	Zip
							<u> </u>
Home Phone	()		Cell Phone ()				
Employer_			Business Phone ()			

HEALTH HISTORY:									
To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health pro							th problems	that	
	you may have, or medications that you may be taking, could have an important interrelationship with the care the							will be receiv	ring.
	Thank you	ı for answering the	following questions.	Your answers are for or	ur records only and will	be considered	confide	ntial.	
Reason for today's office visit'	?						-	.,	
1. Height Weight								Yes	No
•	Weight								
	Have there been any changes in your general health in the past year? Are you under the care of a physician? Date of last visit?								
If so, for what are you b 4. Have you had any illness									
	, operation	or been nospitaliz	ed in the past five yea	ars?					ш
If so, describe		·							
	•		-	•	r moutn?				ш
If so, describe where6. Do you have a prosthetic							-		
6. Do you have a prosthetic7. Have you had a heart val									
•	•	•							
 Have you, or a family men Has a physician or previo 		•							
			t you take antibiotics p	onor to your dentar treat	ment?			U	
HAVE YOU HAD, OR DO YO	YES	NO NO	NOTES			YES	NO	NOT	Ec
	TEO	NO	NOTES		32. Bleeding	TEO	NU	NOT	E 0
					tendency/abnormal				
10. Rheumatic fever?					bleeding?				
11. Damaged heart valves/mitral valve prolapse?					33. Hepatitis, jaundice, or liver disease?				
12. Heart murmur?					34. Infectious mononucleosis?				
13. High blood pressure?					35. Gallbladder trouble?				
14. Low blood pressure?		_			36. Fainting spells?				
15. Chest pain/angina?					37. Convulsions/epilepsy?				
16. Heart attack(s)?		_			38. Stroke?				
17. Irregular heart beat?					39. Thyroid trouble?				
18. Cardiac pacemaker?					40. Diabetes?				
19. Heart surgery?					41. Low blood sugar?				
20. Pneumonia, chronic cough,	_	_			T. Low blood ougur :	_	_		
bronchitis?					42. Kidney trouble?				
21. Asthma?					43. High cholesterol?				
22. Hay fever/sinus problems?					44. On dialysis?				
23. Snoring/sleep apnea?					45. Swollen ankles/ arthritis/joint disease?				
23. Onoring/sieep apriea!	_	_			artimus/joint discase:	_	_		
24. Difficult breathing/other lung					46.		_		
trouble?					Osteoporosis/osteopenia				
25. Tuberculosis?					47. Osteonecrosis?				
26. Emphysema?					48. Stomach ulcers/acid reflux?				
27. Do you smoke? packs									
per day					49. Contagious disease?				
28. Do you use chewing tobacco?					50. Sexually transmitted diseases?				
29. Blood transfusion?					51. Delay in healing?				
30. Blood disorder (eg. anemia)?					52. A tumor or growth?				
os. Blood disorder (og. diferrita)!					53. Chronic fatigue/night				
31. Bruise easily?					sweats?				

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE: WOMEN ONLY: (QUESTIONS 64-67)								
	YES	NO	NOTES			YES	NO	NOTES
54. Immune system problems?				64. Is there a possibility of pregnancy?	?			
55. Are you on a diet?				65. Expected delivery date?				
56.Cancer/radiation/				66. Are vev rurein 20				
chemotherapy?				66. Are you nursing?				
57. History of alcohol abuse?				67. Are you taking birth control pills?				مالته ممسلما منالم
58. History of drug abuse?				Note: Antibiotics (such as penicillin) m	•			•
59. Contact lenses?				Consult your physician/OBgyn for assist IS THERE A FAMILY HISTORY OF:	istance re	garding oth	er metno	as of birth control.
60. Eye disease/glaucoma?						□N•		
61. Mental health problems?				68. Cancer? □Yes 69. Diabetes? □Yes		□No □No		
						□No		
				70. Heart disease? □Yes 71. Anesthesia issues □Yes				
ARE YOU ALLERGIC TO, OF		EACTION TO		ARE YOU NOW TAKING:		□ INO		
ARE TOU ALLERGIC TO, OF	YES	NO	NOTES	ARE TOO NOW TAKING.		YES	NO	NOTES
72. Local anesthetic?	IE9		NOTES	87. Any kind of medication, drug, pills?				NOTES
73. Penicillin?				Aspirin, Vitamin E, Ginko biloba, Aggre				
74. Other antibiotics?				89. Have you ever taken diet pills?	eriox,			
75. Sulfa drugs?				or homeopathic remedy?				
76. Sodium pentothal/				91. Are you taking, or have you ever ta	aken.			
valium/ other tranquilizers?				bone density meds, or bisphosphonate				
77. Aspirin?				92. Tranquilizers, sleeping pills, anti-de		ts, and/or na	arcotics o	on a regular basis?
78. Amoxicillin?						Ū		
79. Codeine or other								
narcotics?								
80. Other medications?								
81. Latex?								
82. Soy?								
83. Eggs/ yolk								
84. Sulfites?				93. Please list any medications you are				
85. Any known allergies?				MEDICATION	DO	OSAGE		FREQUENCY
86. Please list any allergies of	ther than dr	ug allergies:						
If you are beginning a support of all		. In a silvano Alabani An		1- th:::-:		□\/		DN.
If you are having surgery toda in the last 6 hours?	•			Is this visit related to an accident?	ا: ما م مصر ما با	□Yes		□No
Who is driving you home?		□Yes	□No	1 ' ' '	Automobil		ork relate	
who is arrying you nome?				Date of injury Insurance company handling the claim				
Is there any condition concern	ning your ho	alth that the Doct	or chould					
be told about?		aith that the Doct		Claim number				
				Name of attorney / adjustor				
If yes, please describe:				Telephone number ()				
Do you wish to speak to the d	octor privat	oly about anything	.2					
Do you wish to speak to the d	octor privat	eiy about ariytiliriç Yes	J.º □No					
Loortify that I have road and I	understand		-	m. I acknowledge that my questions, if a	any ahai	ıt the inquiri	on not fo	rth above
		•	•	ember of his/her staff, responsible for an		-		
made in the completion of this		will flot flold filly	abotor, or arry other m	ember of mamer stan, responsible for an	ny enois (01 011113510[1]	s unat I Ili	ave
made in the completion of this	o ioiiii.							
v				Y				x
Signature of patient (Parent of	r Guardian if	Minor)		X				
organical of patient (Farent of	. Juanulaii II			Reviewed by				Date

	EEEC 0	PAYMENTS	
We make every effort to keep down the cost of your commanager depending upon special circumstances. An If you have any dental and/or medical insurance we w	are. You can help by paying estimate of the charge for an	upon completion of each visit. Other arrangement by procedure or surgery you may require will be g	iven to you upon request.
Please remember that insurance is considered a meth Some companies pay fixed allowances for vertain pro amount, co-insurance or any other balance not pa and court costs.	cedures and others pay a pe	rcentage of the charge. It is your responsibility	to pay any deductible
x			X
Signature of patient (Parent or Guardian if Minor)			Date
This signature on file is my authorization for the releas benefits otherwise payable to me.	se of information necessary to	o process my claim. I hereby authorize payment	to this doctor named of the
x			X
Signature of patient (Parent or Guardian if Minor)			Date
	AUTH	ORIZATION	
I authorize my surgeon and his/her designated staff, to Furthermore, I authorize the taking of all x-rays require of any information acquired in the course of my exami phone concerning my appointment.	ed as a necessary part of this	s examination. In addition, if medically necessary	, I authorize the release
x	x	×	x
Signature of patient (Parent or Guardian if Minor)	Witness	Doctor	Date
I hereby acknowledge that a copy of this office's N	lotice of Privacy Practices	has been made available to me. I have been g	iven the opportunity to ask
any questions I may have regarding this Notice.			
any questions I may have regarding this Notice. X			x