Coral Springs Oral Surgery

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

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

PATIENT'S DENTAL INSURANCE CO.

Insurance Co. _____

Address _____

Tel. # ( ) _____

Group # _____ ID # _____

DENTAL INS. POLICE HOLDER NAME

Name of Policy Holder _____

Relation to Patient ☐ Self ☐ Spouse ☐ Patient

Sex ☐ Male ☐ Female Date of Birth _____ _____

Street _____

City _____ State _____ Zip _____

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

PATIENT'S DENTAL INSURANCE CO.

Insurance Co. _____

Address _____

Tel. # ( ) _____

Group # _____ ID # _____

DENTAL INS. POLICE HOLDER NAME

Name of Policy Holder _____

Relation to Patient ☐ Self ☐ Spouse ☐ Patient

Sex ☐ Male ☐ Female Date of Birth _____ _____

Street _____

City _____ State _____ Zip _____

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

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

Employer's Name Tel.# ( )

Insurance Co. _____

Address _____

Tel. # ( ) _____

Group # _____ ID # _____

Name of Policy Holder _____

Relation to Patient ☐ Self ☐ Spouse ☐ Patient

Sex ☐ Male ☐ Female Date of Birth _____ _____

Street _____

City _____ State _____ Zip _____

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

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? _____ _____	☐	☐
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		HAVE YOU HAD OR DO YOU CURRENTLY HAVE	Yes	No	NOTES
6	Do you have a prosthetic joint?				32	Convulsions, epilepsy?			
7	Rheumatic fever?				33	Stroke?			
8	Damaged heart valves / mitral valve prolapse?				34	Thyroid trouble?			
9	Heart murmur?				35	Diabetes?			
10	High blood pressure?				36	Low blood sugar?			
11	Low blood pressure?				37	Kidney trouble?			
12	Chest pain, angina?				38	Are you on dialysis?			
13	Heart valve replaced?				39	Swollen ankles, arthritis or joint disease?			
14	Heart attack(s)?				40	Stomach ulcers?			
15	Irregular heart beat?				41	Contagious diseases?			
16	Cardiac pacemaker?				42	Sexually transmitted diseases?			
17	Heart surgery?				43	Do you have any reason to be immunosuppressed?			
18	Bronchitis, chronic cough?				44	Delay in healing?			
19	Asthma?				45	A tumor growth?			
20	Hayfever / Sinus problems?				46	Radiation treatment/chemotherapy?			
21	Sleep Apnea?				47	Chronic fatigue / night sweats?			
22	Emphysema?				48	Are you on a diet?			
23	Difficult breathing / other lung trouble?				49	A history of drug abuse?			
24	Do you smoke? How much?				50	A history of alcohol abuse?			
25	Have you had a history of smoking?				51	Eye disease / glaucoma?			
26	Do you smoke Marijuana?				52	Mental health problems?			
27	Blood disorder such as anemia?				53	A removable dental appliance?			
28	Bruise easily / Blood transfusion?				54	Pain & Clicking of jaws when eating?			
29	Bleeding tendency (abnormal bleed)?				55	Malignant Hyperthermia?			
30	Jaundice, hepatitis or liver disease?				56	Any family history of anesthetic problems?			
31	Fainting spells?								

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 HEATH 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 YOU 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 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. unless prior arrangements have been made with the office manager. 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. 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)