San Luis Oral Surgery & Dental Implant Center

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I.____ Last Name_____ Nickname _____

Birth Date_____ Age____ Soc. Sec. #_____ E-mail _____

Sex Assigned at Birth: ❑ F ❑ M ❑ Other _____ Current Gender Identity: ❑ F ❑ M ❑ Non-Binary ❑ Other_____

Personal Pronouns (select all that apply): ❑ She / Her / Hers ❑ He / Him / His ❑ They / Them / Their ❑ Other _____

Street_____ Apt. ____ City_____ State____ Zip____

Home Tel.(____)_____ Cell.(____)_____ Preferred Contact Phone? ❑ Home ❑ Cell

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Employer _____

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_____

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

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____

Birth Date _____ Tel. (____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not

Marital Status: . . . . . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

Employed: . . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

PRIMARY DENTAL INSURANCE COMPANY:

❑ I have NO Dental Insurance

Insurance Company Name _____

Insurance Company Tel. (____) _____

ID #_____ Group #_____

Plan / Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Insured's Birth Date _____

Insured's S.S. # _____

Insured's Employer _____

Plan Type: ❑ HMO ❑ PPO

PRIMARY MEDICAL INSURANCE COMPANY:

❑ I have NO Medical Insurance

Insurance Company Name _____

Insurance Company Tel. (____) _____

ID #_____ Group #_____

Plan / Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Insured's Birth Date _____

Insured's S.S. # _____

Insured's Employer _____

Plan Type: ❑ HMO ❑ PPO

SECONDARY DENTAL INSURANCE COMPANY:

Insurance Company Name _____

Insurance Company Tel. (____) _____

ID #_____ Group #_____

Plan / Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Insured's Birth Date _____

Insured's S.S. # _____

Insured's Employer _____

Plan Type: ❑ HMO ❑ PPO

SECONDARY MEDICAL INSURANCE COMPANY:

Insurance Company Name _____

Insurance Company Tel. (____) _____

ID #_____ Group #_____

Plan / Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Insured's Birth Date _____

Insured's S.S. # _____

Insured's Employer _____

Plan Type: ❑ HMO ❑ PPO

Patient Name _____

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 problems that you may have, or medications 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.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
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 five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Alcohol intake? If so, drinks per Day _____ Week _____			
32. Blood transfusion?			
33. Blood disorder such as anemia?			
34. Bruise easily?			
35. Bleeding tendency / abnormal bleed?			
36. Hepatitis, jaundice, or liver disease?			
37. Infectious mononucleosis?			
38. Gallbladder trouble?			
39. Fainting spells?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
40. Convulsions / epilepsy?			
41. Stroke?			
42. Thyroid trouble?			
43. Diabetes?			
44. Low blood sugar?			
45. Kidney trouble?			
46. High cholesterol?			
47. Are you on dialysis?			
48. Swollen ankles / arthritis / joint disease?			
49. Osteoporosis / osteopenia?			
50. Osteonecrosis?			
51. Stomach ulcer / acid reflux?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Autoimmune disease?			
56. Delay in healing?			
57. A tumor or growth?			
58. Cancer / radiation therapy / chemotherapy?			
59. Chronic fatigue / night sweats?			
60. Are you on a diet?			
61. Is there a history / treatment for an alcohol use disorder?			
62. Is there a history / treatment for a marijuana or substance use disorder?			
63. Contact lenses?			
64. Eye disease / glaucoma?			
65. Mental health problems / anxiety / depression?			
66. A removable dental appliance?			
67. Pain or clicking of jaws when eating?			

Patient Name _____

WOMEN ONLY: *(QUESTIONS 68–71)*

	Yes	No
68. Is there a possibility of pregnancy?	❑	❑
69. Expected delivery date? _____		
70. Are you nursing?	❑	❑
71. Are you taking birth control pills?	❑	❑

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.*

ARE YOU NOW TAKING:	YES	NO	NOTES
72. Any kind of medication, drug, pills?			
73. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Xarelto, Eliquis, Fish oil)? If so, name of cardiologist or person who regulates PT/INR:			
74. Have you ever taken diet pills?			
75. Any natural product, herbal supplement or homeopathic remedy?			
76. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

78. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other _____

Treating doctor: _____

79. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Preferred Pharmacy _____

Tel. (_____)` _____

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
80. Local anesthetic (numbing meds.)?			
81. Penicillin?			
82. Other antibiotics?			
83. Sulfa drugs?			
84. Sodium pentothal / Valium /other tranquilizers?			
85. Aspirin?			
86. Amoxicillin?			
87. Codeine or other narcotics?			
88. Latex?			
89. Soy?			
90. Eggs / yolk?			
91. Sulfites?			
92. Do you have any known allergies?			

93. Please list anything else you are allergic to (ex: medications, antibiotics, allergies other than drug allergies)

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

Patient Name _____

I certify that I have read and I 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 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** _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. Payment is due the day of service. Other arrangements can be discussed with our office manager depending upon special circumstances. Failure to notify our office at least **48 hours prior to your appointment** will result in a cancelation fee. An estimate of the charge for any procedure or surgery you may require will be given to you. **As a courtesy to you, if you have dental insurance, we will be glad to submit the proper forms to bill your insurance company.**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, coinsurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

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 hereby authorize payment to this provider / practice for the benefits otherwise payable to me.

X _____ **X** _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

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 / imaging 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 to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Doctor** **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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.

I authorize my surgeon and his / her designated staff permission to discuss my treatment with the following parties (ex: spouse, parent, child, caretaker, etc.)

Person's Name _____ Relation _____

Person's Name _____ Relation _____

Person's Name _____ Relation _____

Person's Name _____ Relation _____

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**