



PATIENT INFORMATION:

Pt Nickname Today's Date Referred By Dentist/Dr Friend/Family Website/Search (list) Mr. Mrs. Ms. Dr. First Name M.I. Last Name Sex: Male Female Birth Date: Age: Soc. Sec. # E-mail Street Apt. City State Zip Home Ph. Cell Ph. Have you ever been a patient of our practice? Y N How may we contact you (select all that apply) Home Cell Work E-mail Has a family member ever been a patient of our practice? Y N Dentist Orthodontist Med. Dr. Driver's Lic. # Nearest relative not living with you Ph. Employer Bus. Ph. Personal Payment Type Cash Check Credit Card In case of emergency, please contact Ph. Relation

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT: (The parent requesting treatment for their child is legally responsible for fees for services rendered)

Self (If self, skip this section) Spouse Father Mother Other Name S.S. # Birth Date Age Ph. Cell Ph. E-mail Street Apt. City State Zip Driver's Lic. # Employer Bus. Ph.

SPOUSE OR OTHER GUARANTOR INFORMATION: (If different from above)

Name Relation S.S. # Birth Date Street Apt. City State Zip Ph. Employer Bus. Ph.

INSURANCE INFORMATION:

Student Full Time Part Time Not Employment Status Full Time Part Time Retired Not School Name Address City State Zip Marital Status Married Divorced Widow Single Legally Separated Do you belong to a PPO or HMO? Yes No

PRIMARY DENTAL INSURANCE COMPANY

Employer Bus. Addr. City State Zip Bus. Tel. Plan Ins. Co. Name I.D. # Addr. City State Zip Tel. Group Name Group # Insured Party FIRST NAME LAST NAME Relation Birth Date Sex M F S.S. # Tel. Addr. City State Zip

PRIMARY MEDICAL INSURANCE COMPANY

Employer Bus. Addr. City State Zip Bus. Tel. Plan Ins. Co. Name I.D. # Addr. City State Zip Tel. Group Name Group # Insured Party FIRST NAME LAST NAME Relation Birth Date Sex M F S.S. # Tel. Addr. City State Zip

SECONDARY DENTAL INSURANCE COMPANY

Employer Bus. Addr. City State Zip Bus. Tel. Plan Ins. Co. Name I.D. # Addr. City State Zip Tel. Group Name Group # Insured Party FIRST NAME LAST NAME Relation Birth Date Sex M F S.S. # Tel. Addr. City State Zip

SECONDARY MEDICAL INSURANCE COMPANY

Employer Bus. Addr. City State Zip Bus. Tel. Plan Ins. Co. Name I.D. # Addr. City State Zip Tel. Group Name Group # Insured Party FIRST NAME LAST NAME Relation Birth Date Sex M F S.S. # Tel. Addr. City State Zip

**HEALTH HISTORY:**

**To our patients:** Although oral surgeons primarily treat the area in and around your mouth, health problems or conditions you may have with other parts of your body, or medications you may be taking, could have an effect on the care you will be receiving at AZ Max. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit/chief complaint? \_\_\_\_\_

	<b>Yes</b>	<b>No</b>
1. <b>Height</b> _____ <b>Weight</b> _____ Are you in good health? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have there been any changes in your general health in the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you under the care of a physician? ..... <b>Date of last visit</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, for what are you being treated?</b> _____		
4. Have you had any illness, operation or been hospitalized in the past five years? .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>If so, describe</b> _____		
5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a prosthetic joint / implant? ..... <b>If so, describe where</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a heart valve replacement / artificial heart valve or vascular graft? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you, or a family member, had an unusual or serious reactions to general anesthesia? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>

**HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:**

	YES	NO	NOTES
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10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack (s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells / dizziness / nausea?			
37. Convulsions / epilepsy / seizures?			

**HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:**

	YES	NO	NOTES
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38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble / disease?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

**WOMEN ONLY: (QUESTIONS 64 - 67)**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
64. Is there a possibility of pregnancy? .....	<input type="checkbox"/>	<input type="checkbox"/>	66. Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
65. Expected delivery date? .....	<input type="checkbox"/>	<input type="checkbox"/>	67. Are you taking birth control pills? .....	<input type="checkbox"/>	<input type="checkbox"/>

**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.

**IS THERE A FAMILY HISTORY OF:**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
68. Cancer? .....	<input type="checkbox"/>	<input type="checkbox"/>	70. Heart disease? .....	<input type="checkbox"/>	<input type="checkbox"/>
69. Diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	71. Anesthesia problems? .....	<input type="checkbox"/>	<input type="checkbox"/>

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, Fish oil?)			
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 or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia?			
77. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			
78. Please list any medications you are currently taking:			
Medication	Dosage	Frequency	

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

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours?  Yes  No

Who is driving you home? \_\_\_\_\_

Is there any condition concerning your health that your doctor should be told about?  Yes  No - If Yes, describe \_\_\_\_\_

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

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 \_\_\_\_\_

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. 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.

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, co-insurance 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 doctor name of 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 and 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 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 concerning my appointment(s).

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_

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

**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.

**X** \_\_\_\_\_ **X** \_\_\_\_\_

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