ARIZONA MAXILLOFACIAL SURGEONS P.C.

Patient Information and Health History

PATIENT INFORMATION:

Pt Nickname ____________ **Today's Date** ____________

Referred By ____________ (FIRST NAME) ____________ (LAST NAME) ☐ 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 ____________ (FIRST NAME) ____________ (LAST NAME) Orthodontist ____________ (FIRST NAME) ____________ (LAST NAME) Med. Dr. ____________ (FIRST NAME) ____________ (LAST NAME)

Driver's Lic. # ____________ Nearest relative not living with you ____________ (FIRST NAME) ____________ (LAST NAME) 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 ____________ (FIRST NAME) ____________ (LAST 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 ____________ (FIRST NAME) ____________ (LAST 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 ______

BRINKS AUSTIN D.D.S., M.D.
BRADLEY PORTER D.D.S., M.S.
BRENT BOYSE D.D.S.
GREGORY ROMNEY D.M.D.

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480.830.5866

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?

		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?	☐	☐
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** ______	☐	☐
7.	Have you had a heart valve replacement / artificial heart valve or vascular graft?	☐	☐
8.	Have you, or a family member, had an unusual or serious reactions to general anesthesia?	☐	☐
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
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
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)*

	Yes	No
64. Is there a possibility of pregnancy?	☐	☐
65. Expected delivery date? ______	☐	☐
66. Are you nursing?	☐	☐
67. 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.*

IS THERE A FAMILY HISTORY OF:

		Yes	No
68.	Cancer?	☐	☐
69.	Diabetes?	☐	☐
70.	Heart disease?	☐	☐
71.	Anesthesia problems?	☐	☐

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 perfom 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**