Welcome To Our Practice

Date:_____

Patient: First Name_____ M.I.____ Last Name_____ Nickname_____

Sex: ❑ Male ❑ Female Date of Birth _____ Age____ Soc. Sec.#_____ Email (optional)_____

Street _____ City _____ State _____ Zip_____

Home Tel.# (_____) _____ Business Tel. # (_____) _____ Ext._____ Employer_____

Dentist _____ Medical Doctor_____ Referred By _____

Driver's Lic. #_____ Nearest relative not living with you_____ Tel. # (_____) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account? ❑ **Self** ❑ **Spouse** ❑ **Father** ❑ **Mother** ❑ **Other**_____
(If self, skip to next paragraph)

Name _____ Soc. Sec.#_____ Home Tel. (_____) _____

Street _____ City _____ State _____ Zip_____

Employer_____ Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name_____ Relation _____ Soc. Sec.#_____ Home Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer_____ Tel. (_____) _____

INSURANCE INFORMATION

Patient: Student: Full Time ❑ Part Time ❑ Not ❑ School Name/Address_____

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ _____

Employed: Full Time ❑ Part Time ❑ Retired ❑ Not ❑ Do you belong to a PPO or HMO? Yes ❑ No ❑

PRIMARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan_____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

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

I.D.#_____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel.# (____) _____ Plan _____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party_____ Relation_____

Sex: ❑ M ❑ F Date of Birth_____

Street _____

City, State, Zip _____

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

I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____

Bus. Address_____

Bus. Tel.# (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

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

I.D.# _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel.# (____) _____ Plan _____

Ins. Co. Name_____

Address_____

_____ Tel.# (____) _____

Group # _____ **Group Name** _____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip _____

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

I.D.# _____

Health History

Patient Name _____ DOB _____

Age _____ Height _____ Weight _____

Are you currently seeing a physician? Y☐ N☐ If yes, what are you being treated for?

Have you ever been ***hospitalized*** before? Y☐N☐ If so, for what?

What surgeries have you had in the past?

Do your medications include blood thinnners? Y☐N☐ (for example, coumadin, plavix, or aspirin)

Are you ***allergic*** to any medications, soybeans, eggs, or sulfites? Y☐N☐ If so, what?

Are you ***allergic*** to latex? Y☐N☐

Do you or your family have a history of difficulties wth anesthesia such as malignant hyperthermia? Y☐N☐

if so, what?

Do you have a ***prosthetic joint*** replacement? Y☐N☐

Where is it and when was it placed?

Do you have a ***heart murmur*** or heart valve replacement?	Y☐N☐	Do you wear contact lenses?	Y☐N☐
Have you taken oral steroids at anytime during the past two years?	Y☐N☐	Do you have jaw joint pain or clicking?	Y☐N☐
How much/for how long?			
Do you currently or have you ever smoked?	Y☐N☐	**Women:**	
How much/for how long?		Is there a chance you may be ***pregnant?***	Y☐N☐
Do you drink alcohol?	Y☐N☐	Are you taking oral contraceptive?	Y☐N☐
Have you ever abused alcohol?	Y☐N☐	Are you breast feeding?	Y☐N☐

Do you have or have you ever had. . .

Y	N		Y	N	
❑	❑	chest pain	❑	❑	a blood transfusion
❑	❑	shortness of breath	❑	❑	hepatitis/jaundice
❑	❑	irregular heart beat	❑	❑	a positive HIV test
❑	❑	a pacemaker/defibrillator	❑	❑	liver disease
❑	❑	a heart attack	❑	❑	kidney disease
❑	❑	high blood pressure	❑	❑	thyroid disease
❑	❑	rheumatic fever	❑	❑	diabetes
❑	❑	mitral valve prolapse	❑	❑	low blood sugar
❑	❑	swollen ankles	❑	❑	fainting spells
❑	❑	a stroke	❑	❑	convulsions/seizure disorder
❑	❑	asthma	❑	❑	eye disease/glaucoma
❑	❑	emphysema/COPD	❑	❑	stomach ulcers
❑	❑	chronic bronchitis	❑	❑	immune system difficulties
❑	❑	hay fever/sinus disease	❑	❑	cancer
❑	❑	tuberculosis	❑	❑	radiation/chemotherapy
❑	❑	anemia	❑	❑	a history of illicit drug use
❑	❑	a tendency to bleed	❑	❑	mental health issues
❑	❑	sleep disorders/sleep apnea	❑	❑	a history of diet pills

What medications are you taking?

What herbal medications or vitamins are you taking?

I have read and understand the above questions. I will not hold my surgeon or any of the staff at Oral Surgery Plus responsible for any omissions that I have made completing this form.

Patient _____ Date _____

Parent/Guardian _____ Review Date _____