PATIENT INFORMATION

DATE: _____

NAME: _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

ADDRESS: _____
STREET APT. # CITY STATE ZIP

BIRTHDATE: _____ _____ _____ _____
MO DAY YR. HOME# CELL # WORK #

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE _____ **S.S. #** _____

DENTAL INSURANCE CO.: _____ GROUP NO. _____

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Family Dentist _____

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

	HUSBAND or INSURANCE GUARANTOR (or FATHER if patient is a minor)	**WIFE or INSURANCE GUARANTOR (or MOTHER if patient is a minor)**
Name:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Telephone #:	HOME # CELL # WORK #	HOME # CELL # WORK #
Birthdate/SS #:	MO DAY YR SS #	MO DAY YR SS #
Employer:	EMPLOYER	EMPLOYER
Dental Insurance Co.: Group #:	DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Husband (or Father) ☐ Wife (or Mother) ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME _____ TEL # _____
LAST FIRST M

ADDRESS _____
STREET CITY STATE ZIP

METHOD OF PAYMENT

CHECK ONE:
☐ Cash ☐ Check ☐ Visa or Mastercard

Payment is due at the time of service unless prior arrangements are made with our office manager. There may be a monthly service charge for bills over 90 days due.

INSURANCE

We will bill the insurance of your choice as a courtesy service, **HOWEVER**, if no pay is received from your insurance company **WITHIN 30 DAYS** the responsibility of payment lies with the patient.

AUTHORIZATION

I hereby authorize payment of the group insurance benefits directly to this oral surgery office, that would otherwise be payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the oral surgery office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

_____
STATE DRIVER'S LICENSE NUMBER

X _____ DATE _____

☐ Adult Patient ☐ Husband (or Father) ☐ Wife (or Mother) ☐ Guardian

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HEALTH HISTORY

1. Date of Birth_____ Family Dentist_____

2. Physician (M.D.)_____

3. **Allergic to any medicines?** _____

4. Previous surgeries, anesthetics, hospitalizations? Yes_____ No_____ When_____

5. Have you had or do you presently have Hepatitis, _____ HIV(+), (Aids)_____

6. Do you take medication for bone density now or in the past? Yes_____ No _____

7. Are you undergoing treatment for chronic pain? Yes_____ No _____

8. Present medications, drugs, pills: _____

_____

_____

9. Have you had any of the following, and if so, when?

1. Heart Disease	YES	NO	WHEN	4. Have You Ever Taken:	YES	NO	WHEN
a. Heart Murmur				a. Blood Thinner			
b. High Blood Pressure				b. Cortisone (Steroids)			
c. Rheumatic Fever				c. Digitalis			
d. Heart Attack				d. Nitroglycerin			
e. Stroke				5. Diabetes (Sugar)			
2. Lung Disease				6. Abnormal Bleeding			
a. Asthma				7. Epilepsy			
b. Emphysema (COPD)				8. Anemia			
c. Bronchitis				9. Thyroid Problems			
d. Tuberculosis				10. Radiation Treatment			
3. Kidney, Liver Disease				11. Stomach Ulcer			
a. Hepatitis				12. Are You Pregnant			
b. Jaundice				13. Other			

10. Have you had an unusual reaction to being put to sleep? _____

11. Do you now have a cough or cold? _____

12. ANSWER THE FOLLOWING QUESTIONS **only if going to sleep**

A.) Have you had anything to EAT or DRINK within the last 6 hours? Yes_____ No _____
B.) Are you wearing CONTACT LENSES? Yes_____ No _____
C.) Do you have someone with you to drive you home? Yes_____ No _____