Welcome to O•S•A Southcoast

Date _____

PATIENT INFORMATION

1.IP

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

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec# _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (___) _____ Cell. (____) _____ Have you ever been a patient of our practice? ❑Yes ❑No

Dentist _____ Medical Doctor _____ Referred By _____

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

Employer _____ Bus. Tel. (____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

❑ If Patient is 17 or younger, Parent / Guardian must sign

(If self, skip to next section)

Name _____ S.S.# _____ Birth Date _____ Age ___ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel (____) _____

INSURANCE INFORMATION

1.I0

Student: ❑ Full Time ❑ Part Time ❑ Not School Name / Address _____

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

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

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____

Bus. Tel (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

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 Birth Date _____

Street _____

City, State, Zip _____

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

I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

❷

1.I1

Employer _____

Bus. Address _____

Bus. Tel (____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

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 Birth Date _____

Street _____

City, State, Zip _____

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

I.D.# _____

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 surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form. Oral Surgery Associates Southcoast prohibits the use of video recording or any portable communication device including cell phones during surgery or during recovery.

Signature of patient: X 1. _____ **Reviewed by: X** _____ **Date: X**_____
(Parent or Guardian if minor)

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical 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. This signature on file is my authorization for release of information necessary to process my claim. I hereby authorize payment to this doctor of the benefits otherwise payable to me.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute 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 of 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. **There is a $35.00 fee for any returned check.**

Signature of patient: *(Parent or Guardian if minor)* **X 2.** _____**Date: X**_____

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 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.

I hearby 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.

Signature of patient: *(Parent or Guardian if minor)* **X 3.** _____**Date: X**_____

HEALTH HISTORY

To our Patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a 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
99. Are you in good health? _____ Height _____ Weight _____	❑	❑
100. Have there been any changes in your general health in the past year? _____	❑	❑
101. Are you under the care of a physician? _____ Date of last visit _____	❑	❑
If so, for what are you being treated? _____		
102. Have you had any illness, operation or been hospitalized in the past five years? _____	❑	❑
If so, describe _____		
103. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? _____ *If so, describe where* _____	❑	❑
104. Do you have a prosthetic joint / implant? *If so, describe where* _____	❑	❑
105. Have you had a heart valve replacement or vascular graft? _____	❑	❑
105A. Are you pregnant? _____	❑	❑

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...	Yes	No	Notes
106 Rheumatic fever			
107 Damaged heart valves / mitral valve prolapse?			
108 Heart murmur?			
109 High blood pressure?			
110 Low blood pressure?			
111 Chest pain / angina?			
112 Heart attack(s)?			
113 Irregular heart beat?			
114 Cardiac pacemaker?			
115 Heart surgery?			
116 Bronchitis, chronic cough?			
117 Asthma?			
118 Hay fever/sinus problems?			
119 Snoring/sleep apnea?			
120 Difficult breathing/other lung trouble?			
121 Tuberculosis?			
122 Emphysema?			
123 Do you smoke?			
124 Do you use chewing tobacco?			
125 Blood transfusion?			
126 Blood disorder such as anemia?			
127 Bruise easily?			
128 Bleeding tendency/abnormal bleed?			
129 Hepatitis, jaundice, or liver disease?			
130 Infectious mononucleosis?			
131 Gallbladder trouble?			
132 Fainting spells?			
133 Convulsions/epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ...	Yes	No	Notes
134 Stroke?			
135 Thyroid trouble?			
136 Diabetes?			
137 Low blood sugar?			
138 Kidney Trouble?			
139 Are you on dialysis?			
140 Swollen Ankles, arthritis or joint disease?			
141 Stomach ulcers?			
142 Contagious diseases?			
143 HIV / AIDS?			
144 Sexually transmitted diseases?			
145 Problems with the immune system?			
146 Delay in healing?			
147 A tumor or growth?			
148 Radiation therapy/chemotherapy?			
149 Chronic fatigue/night sweats?			
150 Are you on a diet?			
151 A history of drug abuse?			
152 A history of alcohol abuse?			
153 Contact lenses?			
154 Eye disease/glaucoma?			
155 Mental health problems?			
156 A removable dental appliance?			
157 Pain and clicking of jaws when eating?			
158 Malignant hyperthermia?			

MEDICATION *Are you now taking ...*		Yes	No	Notes
201	Any kind of medication, drug, pills?			
202	Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
203	Have you ever taken diet pills?			
204	Any natural product, herbal supplement or homeopathic remedy?			
205	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva)?			
206	Have you ever taken tranquilizers, sleeping pills, anti depressants, and/or narcotics on a regular basis? If so, please list:			
207	Please list any medications you are currently taking: _____ _____			

Is there any condition concerning your health that the doctor should be told about?_____

❑ Yes ❑ No *(if so, describe)*_____

_____

Do you wish to speak to the doctor privately about anything?

❑ Yes ❑ No

Is there a FAMILY HISTORY of:		
	310 Cancer:	❑ Yes ❑ No
	302 Diabetes:	❑ Yes ❑ No
	403 Heart Disease:	❑ Yes ❑ No
	304 Anesthetic Problems:	❑ Yes ❑ No

ALLERGIES - Are you allergic to, or had a reaction to...		Yes	No	Notes
208	Local anesthetic (numbing med.)?			
209	Penicillin?			
210	Other antibiotics?			
211	Sulfa Drugs?			
212	Sodium pentothal, Valium, or other tranquilizers?			
213	Aspirin			
214	Codeine or other narcotics?			
215	Other medications?			
216	Latex?			
217	Soy?			
218	Eggs / Yolk?			
219	Sulfites?			
220	Please list any allergies other than drug allergies: _____			

IN CASE OF EMERGENCY, CONTACT:

Name_____

Home Tel. (____) _____

Bus. Tel. (____)_____