Allergies:

Center for Oral Facial & Implant Surgery
Associates in Oral & Maxillofacial Surgery, P.C.

PATIENT INFORMATION:

Today's Date _____

First Name _____ Middle Initial_____ Last Name _____

Preferred Name _____Soc. Sec.# _____ Birth Date _____ Age _____

Sex: ❑ Male ❑ Female ❑ Other _____ Race: ❑Caucasian ❑Black ❑Hispanic ❑Asian ❑Other _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell (_____) _____ E-mail _____

Dentist_____ _____ Orthodontist _____ _____ Physician _____ _____
(FIRST NAME / LAST NAME / FIRST NAME / LAST NAME / FIRST NAME / LAST NAME)

Preferred Pharmacy _____ Tel. (_____) _____

Referred By _____ _____ Tel. (_____) _____
(FIRST NAME / LAST NAME)

Employer _____ Occupation _____

In case of emergency, please contact _____ Tel (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ _____ S.S.# _____ Birth Date: _____ Age _____
(FIRST NAME / LAST NAME)

Tel. (_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

STUDENT STATUS:

Student: ..... ❑ Full Time ❑ Part Time

PRIMARY DENTAL INSURANCE COMPANY:

Group# _____ I.D. # _____

Ins. Co. Name _____

Claims Address_____ _____ _____ _____
(ADDRESS / CITY / STATE / ZIP)

Policy Holder _____ _____
(FIRST NAME / LAST NAME)

Relation to Policy Holder_____

Birth Date _____ Sex: ❑ Male ❑ Female

S.S. # _____

Employer _____

PRIMARY MEDICAL INSURANCE COMPANY:

Group# _____ I.D. # _____

Ins. Co. Name _____

Claims Address_____ _____ _____ _____
(ADDRESS / CITY / STATE / ZIP)

Policy Holder _____ _____
(FIRST NAME / LAST NAME)

Relation to Policy Holder_____

Birth Date _____ Sex: ❑ Male ❑ Female

S.S. # _____

Employer _____

SECONDARY DENTAL INSURANCE COMPANY:

Group# _____ I.D. # _____

Ins. Co. Name _____

Claims Address_____ _____ _____ _____
(ADDRESS / CITY / STATE / ZIP)

Policy Holder _____ _____
(FIRST NAME / LAST NAME)

Relation to Policy Holder_____

Birth Date _____ Sex: ❑ Male ❑ Female

S.S. # _____

Employer _____

SECONDARY MEDICAL INSURANCE COMPANY:

Group# _____ I.D. # _____

Ins. Co. Name _____

Claims Address_____ _____ _____ _____
(ADDRESS / CITY / STATE / ZIP)

Policy Holder _____ _____
(FIRST NAME / LAST NAME)

Relation to Policy Holder_____

Birth Date _____ Sex: ❑ Male ❑ Female

S.S. # _____

Employer _____

Patient Name: _____

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 and deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

X _____
Patient Initials *(Parent or Guardian if Minor)*

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 and photographs required as a necessary part of this examination and treatment. 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.

X _____
Patient Initials *(Parent or Guardian if Minor)*

PATIENTS RIGHTS & NOTICE OF PHYSICIAN OWNERSHIP

1. I have received a copy in advance of the "Patient Rights and Responsibilities" in a language and manner that I or my representative understands.

2. I have received a copy in advance of the "Notice of Physician Ownership" in a language and manner that I or my representative understands.

X _____
Patient Initials *(Parent or Guardian if Minor)*

I hereby acknowledge that a copy of this office's Notice of Privacy Practices, per HIPAA has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice. This practice provides this form to comply with HIPAA.

X _____
Patient Initials *(Parent or Guardian if Minor)*

PATIENT COMMUNICATION

I authorize the following people to receive information regarding my treatment:

_____

_____

_____

CONSENT TO ANTIBODY TESTING

In the event of an accidental exposure to blood or other body fluids through a needle stick, cut, mucous membrane contact, or the like, the undersigned consents to the appropriate tests for the presence of the Hepatitis B & C virus and the antibody for the Human Immunodeficiency Virus (HIV), which is the virus believed to cause AIDS (Acquired Immune Deficiency Syndrome). The patient will be informed of any positive results, and all such results will be treated as confidential by Associates in Oral & Maxillofacial Surgery. There is no charge to the patient.

X _____
Patient Initials *(Parent or Guardian if Minor)*

ADVANCE DIRECTIVES

Resuscitation measures are executed regardless of the contents of the patient's Advance Directives, those Directives will be placed in the patient's chart. In the event of an unanticipated transfer to the hospital, a copy of the Advance Directives will be provided to the hospital with the other elements of the patient's record.

X _____
Patient Initials *(Parent or Guardian if Minor)*

SIGNATURE

I HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE INFORMATION.

X _____ **X** _____
Signature of Patient *(Parent or Guardian if Minor)* **Date**

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HEALTH HISTORY

To our patients: *Although oral and maxillofacial surgeons primarily treat the area in and around your mouth, your mouth is 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.*

Patient Name: _____ Weight: _____

Date of Birth: _____ Height: _____

Reason for visit: _____

Prior Surgeries/Hospitalizations		Medications (Prescribed/Over the Counter)			Allergies (Food and Drug)
	DATE	NAME	DOSE	FREQUENCY	REACTIONS
		❑ Taking diet drugs/medications			❑ Latex allergy
		❑ Taking blood thinner			

Anesthesia Related Information

Have you ever had general anesthesia? ❑No ❑Yes

Complications with anesthesia: ❑No ❑Yes, reaction: _____

History of malignant hyperthermia: ❑No ❑Yes

Family history of malignant hyperthermia: ❑No ❑Yes

Family history of complications with anesthesia: ❑No ❑Yes, reaction: _____

Social History

Alcohol Use: ❑Not at all ❑Daily ❑Weekly Monthly

Substance/IV Drug use: ❑Current, type:_____ ❑Former. type:_____ ❑Never

Smoking status: ❑Current ❑Former ❑Never Packs/day_____ Years _____

Chewing tobacco use: ❑Current ❑Former ❑Never

For Women

Are you currently pregnant? ❑No ❑Yes Nursing? ❑No ❑Yes

Post Menopause/Hysterectomy? ❑No ❑Yes

Birth control method: ❑None ❑Type,_____

Please check any of the conditions below which you have been diagnosed

Neurological

- ❑ Migraines
- ❑ Seizures
- ❑ Fainting Spells
- ❑ Developmental Delay
- ❑ Stroke, Date_____
- ❑ Parkinson's
- ❑ ADD/ADHD
- ❑ Autism
- ❑ Alzheimer's
- ❑ Dementia
- ❑ TIA
- ❑ Tremors

Psychological

- ❑ Anxiety Disorder
- ❑ Depression
- ❑ Other, please lists: _____

Endocrine

- ❑ Diabetes (Insulin) Last AIC _____
- ❑ Thyroid Disorder
- ❑ Diabetes (Non-Insulin) Last AIC _____
- ❑ Adrenal Insufficiency

Gastrointestinal

- ❑ GERD/ Acid Reflux
- ❑ Gastroparesis
- ❑ Inflammatory Bowel Disease
- ❑ Stomach Ulcers
- ❑ Liver Disease
- ❑ Hepatitis

EENT

- ❑ Eye Disease
- ❑ Glaucoma
- ❑ Sinus Surgery
- ❑ Facial Surgery
- ❑ Oral Cancer
- ❑ Radiation to face or neck
- ❑ Herpes simplex type 1 (Cold Sores)
- ❑ Unhealed mouth sores
- ❑ Pain/Clicking of jaw
- ❑ Throat Cancer

- ❑ Kidney Disorder
  If checked, please specify_____
  Dialysis, schedule _____

- ❑ Other problem with immune system
  Specify: _____
- ❑ Autoimmune Disorder
  Specify: _____
- ❑ History of Rheumatic Fever
- ❑ Delay in healing

Cardiovascular

- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Coronary Artery Disease
- ❑ Congestive Heart Failure
- ❑ Irregular Heart Beat Type: _____
- ❑ Mitral Value Prolapse
- ❑ Blood Clots (Legs, Lungs)
- ❑ Other not listed: _____
- ❑ Heart Attack Date: _____
- ❑ Heart Stents Date: _____
- ❑ Implanted Pacemaker/Defibrillator
- ❑ Chest Pain/Angina
- ❑ Damaged Heart Value
- ❑ Artificial Heart Value
- ❑ CABG, other surgery: _____

Respiratory

- ❑ Emphysema
- ❑ COPD
- ❑ Asthma
- ❑ Smoker
- ❑ Vape Use
- ❑ Marijuana Use
- ❑ Tubercucosis (TB)
- ❑ Obstructive Sleep Apnea
  - ❑ CPAP Use
- ❑ COVID with hospitalization
- ❑ Shortness of breath at rest
- ❑ Recent respiratory infection
- ❑ Recurrent respiratory infection
- ❑ Oxygen use at home

Musculoskeletal

- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Rheumatoid Arthritis
- ❑ Arthritis
- ❑ Osteonecrosis
- ❑ Fibromyalgia
- ❑ Joint Replacement
- ❑ Cervical Fusion
- ❑ Other spinal Surgery: _____
- ❑ Bisphosphonate Use
  ex: Fosomax, IV Zometa, Prolia, Xgeva, Reclast
  Medication: _____
  Years of use: _____
  Frequency: _____
  ❑ Current ❑ Former

Hematology

- ❑ Anemia
- ❑ Blood Disorder Type: _____
- ❑ HIV/AIDS
- ❑ Blood Transfusion Year: _____
- ❑ Sickle Cell Disease
- ❑ Bleeding Issues

- ❑ Cancer, type: _____ ❑ Surgery ❑ Radiation ❑ Chemotherapy

- ❑ Any other condition concerning your health, please list:
  _____
  _____

I certify that I have read and I understand the questions above. 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**