

ORAL SURGERY

NEW PATIENT INFORMATION QUESTIONNAIRE

PLEASE PRINT

Date: _____

PATIENT NAME: Last _____ First _____ Middle _____

Nickname (if any) _____ Birthdate _____

Home Phone (_____) _____ Sex _____ Height _____ Weight _____ Age _____

Address _____ City _____ Zip _____

Patients social security # _____ E-Mail Address _____

Circle One: Parents Are: married Widowed Divorced Separated

FINANCIALLY RESPONSIBLE PERSON(S):			
Name _____			
Last	First	MI	Relationship to Patient _____
Address _____			Home Phone _____
City _____			Cell/Daytime Phone _____
Zip _____			Social Sec. No. _____
Previous Address _____			Birthdate _____
(If less than 3 years at present address)			Age _____
Employer _____			Driver's Lic. No. _____
Spouse's First Name _____			Occupation _____
MI _____			# Years Employed _____
Last _____			Spouse's Employer _____
=====			Cell/Daytime Phone _____
Name _____			
Last	First	MI	Relationship to Patient _____
Address _____			Home Phone _____
City _____			Cell/Work Phone _____
Zip _____			Social Sec. No. _____
Previous Address _____			Birthdate _____
(If less than 3 years at present address)			Age _____
Employer _____			Driver's Lic. No. _____
Spouse's First Name _____			Occupation _____
MI _____			# Years Employed _____
Last _____			Spouse's Employer _____
=====			Cell/Work Phone _____

DENTAL/ORTHODONTIC INSURANCE INFORMATION:	
Insured's Name _____	Insured's Social Security Number _____
Insurance Company _____	Group No. _____
Insurance Co. Address _____	Local No. _____
Do you have dual coverage? Yes ___ No ___ If yes: _____	Insured's Employer _____
Insured's Name _____	Insured's Social Security Number _____
Insurance Company _____	Group No. _____
_____	Local No. _____

DENTIST: Name _____ Address _____
 Phone (_____) _____ Date Last Checked _____

REFERRAL: Whom may we thank for referring you to our office?

Please **INDIVIDUALLY** circle the appropriate answer to each question completely and accurately. Answers for our records are strictly for our office and are confidential.

Part A. General Health Questions

- 1. Are you in good health?..... Yes No
- 2. Are you having pain or discomfort at this time?..... Yes No
- 3. Have there been any changes in your general health in the past year?..... Yes No
If so, what? _____
- 4. Have you been under the care of a medical doctor during the past 2 years? Yes No
If so, for what are you being treated? _____
- 5. Last visit to a medical doctor? Date? _____
- 6. Have you been a patient in the hospital? Yes No
Reason: _____ Date _____
- Reason: _____ Date _____
- Reason: _____ Date _____

Part B. Medical Conditions- Indicate which of the following have had previously or currently

1. Heart-----

- a. Heart Failure..... Yes No
- b. Heart Disease..... Yes No
- c. Heart Attack..... Yes No
- d. Irregular Heart Beat..... Yes No
- e. Angina Pectoris..... Yes No
- f. Myocardial Infarction..... Yes No
- g. Congenital Heart Disease... Yes No
- h. Heart Murmur..... Yes No
- i. Mitral Valve Prolapse..... Yes No
- j. Rhuematic Fever..... Yes No
- k. Arterisclerosis..... Yes No
- l. Heart Pacemaker..... Yes No
- m. Stroke..... Yes No
- n. High Blood Pressure..... Yes No
- o. Fainting Spells..... Yes No
- p. Heart Surgery (Bypass/Stem). Yes No
- q. Damaged Heart Valves..... Yes No
- r. Artificial Heart Valve..... Yes No

2. Lungs-----

- a. Emphysema..... Yes No
- b. Chronic Cough..... Yes No
- c. Tuberculosis..... Yes No
- d. Asthma..... Yes No
- e. Bronchitis..... Yes No
- f. Hay Fever..... Yes No
- g. Difficulty Breathing..... Yes No
- h. Any Other Lung Trouble..... Yes No
What? _____
- i. Do you Smoke?..... Yes No
if so, for how long? _____
How many per day? _____

3. Liver-----

- a. Hepatitis A (infectious).. Yes No
- b. Hepatitis B (serum)..... Yes No
- c. Hepatitis C..... Yes No
- d. Liver Disease..... Yes No
- e. Yellow Jaundice..... Yes No

4. Kidney-----

- a. Kidney Trouble..... Yes No
- b. Dialysis Treatment..... Yes No

5. Gastrointestinal

- a. Ulcers..... Yes No
- b. Diverticulitis..... Yes No
- c. Bowel Problems..... Yes No

6. Endocrine

- a. Diabetes..... Yes No
- b. Thyroid Problem..... Yes No
- c. Low Blood Sugar..... Yes No
- d. Cancer..... Yes No
- e. Cold Sore/Fever Blisters. Yes No
- f. Other Contagious Diseases... Yes No
- g. Glaucoma..... Yes No

7. Prosthesis

- a. Artificial Joints (hip, knee) . Yes No
- b. Implanted plates, screws, pins etc?...
..... Yes No

8. Surgery

- a. Ever had any type of surgery? ...
..... Yes No If so, Please list

9. Blood-----

- a. Blood Transfusion.... Yes No
- b. Hemophilia..... Yes No
- c. Anemia..... Yes No
- d. Sickle Cell Disease..... Yes No
- e. Bruise Easily..... Yes No
- f. Blood Disorder..... Yes No
- g. Abnormal Bleeding..... Yes No
- h. Infectious Mononucleosis Yes No

10. Other-----

- a. Sinus Trouble..... Yes No
- b. Cortisone Medicine.... Yes No
- c. Drug Addiction..... Yes No
- d. Epilepsy or Seizures..... Yes No
- e. Radiation Therapy..... Yes No
- f. Chemotherapy..... Yes No
- g. Nervousness..... Yes No
- h. Tumors..... Yes No
- i. Developmentally Disabled Yes No
- j. Allergies or Hives..... Yes No
- k. Swollen Ankles..... Yes No
- l. Arthritis or Joint Disease... Yes No
- m. Delayed Healing..... Yes No
- n. Mental Health Problems.... Yes No
- o. Alcohol Addiction..... Yes No
- p. Severe Headaches..... Yes No
- q. Contact lenses..... Yes No
- r. Chronic Fatigue..... Yes No
- s. Pain & Clicking in Jaw Joints
..... Yes No
- t. Are you on a diet..... Yes No

Next Page please

Part C. Allergies

Are you allergic to, or have you had a reaction to any of the following?

- 1. Local Anesthesia? (Novocain, Epinephrine, Penicillin, etc?) Yes No; If so, Please explain _____
- 2. Sodium Pentothal, Valium or Tranquilizers? Yes No; If so, Please explain _____
- 3. Aspirin?.....Yes No
- 4. Codeine or other Narcotics?Yes No
- 5. Latex?Yes No
- 6. Other Medications?Yes No Please list _____
- 7. Allergies other than drugs?.....Yes No Please list _____
- 8. Soybean.....Yes No
- 9. Egg.....Yes No

Part D. Medications

- 1. Are you taking any kind of medication, drug or pills for any purpose? Yes No If so, please explain _____
- 2. Anticoagulants? (Blood thinners, Aspirin, etc.)..... Yes No
- 3. Tranquilizers?Yes No
- 4. Cortisone?Yes No
- 5. Are you or have you ever taken anyu recreational or street drugs?Yes No
- 6. Are you taking any herbal supplements or non-prescription pills?.....Yes No
- 7. Are you taking or have you ever taken Bisphophonates (Fosmax, Actonel, Aredia or Zometa for osteoporodid, or chemotherapy for multiple myeloma, etc)?Yes No

Part E. Anesthesia

- 1. Is there any condition or problem concerning your health or family anesthetic history that the doctor should know about? Yes No
- 2. I can climb a flight of stairs.....(Circle best answer).....Without resting Resting halfway Resting at the top
- 3. Do you have PorphyriaYes No
- 4. Have you or anyone else in your family has malignant hypothermia or other complications while under general anesthesia....Yes No

Part G. Woman only Anesthesia

- 1. Is there any possibility that you may be pregnantYes No
- 2. Are you nursing?.....Yes No
- 3. Are you taking Birth control pills?Yes No
- 4. Have you had a breast Augmentatio surgery?.....Yes No If yes, when? _____
- 5. _____

**Antibiotics (such as penicillin) nay decrease the effectiveness of birth control pill. Consult your physician or gynecologist for assistance regarding additional methods of birth control. Initial: _____

I certify that I have read and understood the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. To the best of my knowledge, all of the proceeding are true and correct. If I ever have any change in my health of if my medications change, I will inform my oral surgeon at the earliest possible time. I will not hold Dr Hou, Dr Apel or any staff responsible for any errors or omissions that I have made in completion of this form.

Signature of Patient/ Parent or Guardian _____ Date _____

Doctors Signature _____ Date _____

Financial Policy Agreement

Re: Private insurance coverage

We are pleased to extend the COURTESY of billing your insurance company for you. In order to provide you this service, we must have your complete cooperation and update of insurance coverage information.

Please remember the insurance is an agreement between you and your insurance company. Therefore, if any problem arises with the carrier, our office will provide your insurance company with any additional information necessary for resolution, but it will ultimately become the insurer's responsibility to handle any matters that occur.

I understand that if the insurance does not pay the full expected benefit, for any reason, I am responsible for all costs of the remaining balance.

Signature

Date

Oral Surgery/ Anesthesiology Acknowledgement of Independent Contractor Status

This document is to advise you that your Oral Surgeon/ Anesthesiologist is not an employee or agent of this office. Your signature below acknowledges that you understand and agree that your Oral Surgeon/Anesthesiologist is an independent contractor. It further acknowledges that you understand that services received at any facility and that Abari Orthodontics/Oral Surgery will not be responsible for the actions of or the services provided by your Oral Surgeon/Anesthesiologist. All billing or other services performed on behalf of the Oral Surgeon/ Anesthesiologist are done as an accommodation.

Acknowledged and agreed.

Signature

Date