Patient Information

Welcome to our office; Please provide us with information requested below. All information is kept confidential.

Patient Name: _____ **Today's Date:** _____

Referring Doctor: _____ **Referring Doctor Phone:** _____

Date of Birth: _____ **Age:** _____ **Sex: M/F** **SS:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Employer: _____ **Work Phone:** _____

(Circle One) Married Single Divorced Widowed

Spouse's Name: _____ **Spouse's Phone:** _____

Responsible Party's Name (If Patient is under Age 18) _____

Responsible Party's Phone: _____

Responsible Party's Soc Sec #: _____ **Date of Birth:** _____

Insurance Information

Dental Insurance Company Name: _____

Policy Holder Name: _____ **Policy Holder Date of Birth:** _____

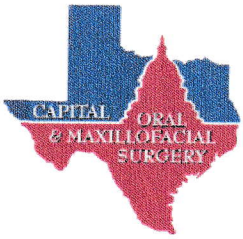
Policy Holder Soc Sec #: _____ **Relationship to insured:** _____

Address of Policy Holder (if different from above): _____

City: _____ **State:** _____ **Zip:** _____

Policy Holder Phone #: _____ **Employer:** _____

Signature of Patient or Responsible Party: _____



HIPAA Privacy Policy

Acknowledgement of Privacy Practices By my signature below, I acknowledge that I have read the Notice of Health Insurance Portability and Accountability Act (HIPAA) and Financial Policy of Capital Oral & Maxillofacial Surgery that is available to review upon request. I understand that Capital Oral & Maxillofacial Surgery reserves the right to change their notice and policies, & upon request will mail a copy of any revised notice to the address I have provided. Under the HIPAA, I understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I may revoke this consent in writing, except to the extent thatCapital Oral & Maxillofacial Surgery has already taken action in reliance thereon.

Signature: _____ **Date:** _____

Financial & Cancellation Policy

I understand I will be required to pay 50% of my surgery cost to reserve my surgery appointment. In the event of default, collection & legal fees are the responsibility of the patient/guardian. Patients are typically on a waiting list to reserve time in our office. Without proper notice, patients on this wait list do not have the opportunity to fill an open appointment. In an effort to keep costs low, Capital Oral & Maxillofacial Surgery reserves the right to charge a fee for any missed, canceled, or re-scheduled appointments. The fees will be as follows: $100 for surgery appointments with less than three (3) business day notice. Our e-mail reminder service is offered as a courtesy. You are responsible for confirming or notifying us of any issues regarding a scheduled appointment. If you have questions about our financial policy or cancellation policy, please request to speak with us personally.

Signature: _____ **Date:** _____

Patient's Name: **Today's Date:** **Date of Birth:**

HEALTH HISTORY:

To our patients: *Although oral 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.*

Reason for today's office visit?_____

		Yes	No
1.	***Height***_____ ***Weight***_____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated?_____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe_____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where_____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia or IV sedation?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia or IV sedation?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Alcohol intake? If so, drinks per Day _____ Week _____			
32. Blood transfusion?			
33. Blood disorder such as anemia?			
34. Bruise easily?			
35. Bleeding tendency / abnormal bleed?			
36. Hepatitis, jaundice, or liver disease?			
37. Infectious mononucleosis?			
38. Gallbladder trouble?			
39. Fainting spells?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
40. Convulsions / epilepsy?			
41. Stroke?			
42. Thyroid trouble?			
43. Diabetes?			
44. Low blood sugar?			
45. Kidney trouble?			
46. High cholesterol?			
47. Are you on dialysis?			
48. Swollen ankles / arthritis / joint disease?			
49. Osteoporosis / osteopenia?			
50. Osteonecrosis?			
51. Stomach ulcer / acid reflux?			
52. COVID–19?			
53. Contagious diseases?			
54. Sexually transmitted diseases?			
55. Problems with immune system? Possibly from medication / surgery, etc.			
56. Autoimmune disease?			
57. Delay in healing?			
58. A tumor or growth?			
59. Cancer / radiation therapy / chemotherapy?			
60. Chronic fatigue / night sweats?			
61. Are you on a diet?			
62. Is there a history / treatment for an alcohol use disorder?			
63. Is there a history / treatment for a marijuana or substance use disorder?			
64. Contact lenses?			
65. Eye disease / glaucoma?			
66. Mental health problems / anxiety / depression?			
67. A removable dental appliance?			
68. Pain or clicking of jaws when eating?			

Patient Name _____

WOMEN ONLY: *(QUESTIONS 69–72)*

	Yes	No
69. Is there a possibility of pregnancy?	❑	❑
70. Expected delivery date? _____		
71. Are you nursing?	❑	❑
72. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
73. Any kind of medication, drug, pills?			
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
75. Have you ever taken diet pills?			
76. Any natural product, herbal supplement or homeopathic remedy?			
77. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

78. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

79. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other _____

Treating doctor: _____

80. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
81. Local anesthetic (numbing meds.)?			
82. Penicillin?			
83. Other antibiotics?			
84. Sulfa drugs?			
85. Sodium pentothal / Valium /other tranquilizers?			
86. Aspirin?			
87. Amoxicillin?			
88. Codeine or other narcotics?			
89. Latex?			
90. Soy?			
91. Eggs / yolk?			
92. Sulfites?			
93. Do you have any known allergies?			

94. Please list any allergies other than drug allergies:

95. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____