FALLSGROVE ORAL & MAXILLOFACIAL SURGERY

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Diplomate of American Board of Oral & Maxillofacial Surgery

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PATIENT INFO

First Name Middle Int. Last Name

Your name_____

Address_____

City_____State_____Zip_____

Date of Birth_____ Female____ Male____

Social Security #_____

Home telephone_____

Work telephone _____ Cell _____

Employer/School _____

Email

Policy holder responsible for account:

Self_____Spouse_____Parent_____Guardian_____
First Name Middle Int. Last Name

Name_____

Employer_____

Employer's Address _____

Work telephone _____

Social Security # _____

Date of Birth_____

MEDICAL INSURANCE

Company Name _____

Policy Holder _____

Membership # _____

Group #_____

DENTAL INSURANCE

Company Name_____

Policy Holder_____

Membership #_____

Group #_____

Name of general dentist_____

Who referred you to our office?_____

MEDICAL INFORMATION

The answers that you provide to the following questions will help us determine the proper treatment for you. These records are kept confidential in our office.

Yes	No	
____	____	1. Are you in good health?
____	____	2. Has there been any changes in your general health within the last year?
____	____	3. Are you now under the care of a physician? If so, what for?
		_____
		_____
		_____
		_____
		Name of Medical Doctor\Phone No.
		_____
____	____	4. Have you had any serious illnesses, injuries or operations? If so, please list:
		_____
		_____
		_____
		_____
____	____	5. Have you ever stayed overnight in a hospital?

Yes	No	
____	____	6. Do you have or have you ever had any of the following medical conditions:
____	____	a. Heart Problems:
____	____	1. Rheumatic fever or rheumatic heart disease.
____	____	2. Heart murmur
____	____	3. High or low blood pressure
____	____	4. Chest pains
____	____	5. Previous heart attack
____	____	6. Shortness of breath after mild exercise
____	____	7. Ankle swelling
____	____	8. Pacemaker or artificial valves
____	____	9. Bypass surgery
____	____	b. Are you allergic to or ever had a bad reaction to any medicines? If so, which ones? _____
		_____
		_____
____	____	c. Do you have asthma or hay fever?
____	____	d. Do you have hives or a skin rash?

Continued on reverse side

Yes	No	
____	____	e. Do you have fainting spells or seizures?
____	____	f. Are you a diabetic or have blood sugar problems?
____	____	g. Do you have hepatitis, jaundice or liver disease?
____	____	h. Do you have arthritis?
____	____	i. Do you have stomach ulcers?
____	____	j. Do you have kidney disease?
____	____	k. Do you have breathing problems or a chronic cough?
____	____	l. Have you ever had tuberculosis?
____	____	m. Have you ever had venereal disease?
____	____	n. Have you had any type of cancer?
____	____	o. Do you have glaucoma?
____	____	p. Do you have HIV or AIDS?
____	____	7. Have you had excessive bleeding from an extraction or previous surgery?
____	____	8. Do you bruise easily?
____	____	9. Have you ever required a blood transfusion?
____	____	10. Is there any reason to believe that your immune system may be compromised?
____	____	11. Do you have any blood disorders?
____	____	12. Are you anemic?
____	____	13. Are you currently taking any medications or drugs? Please list: _____ _____ _____

Yes	No	
____	____	14. Have you ever had any radiation treatments or chemotherapy?
____	____	15. Women: Are you pregnant?
____	____	Do you take oral contraceptives?
____	____	16. Have you had any serious trouble associated with previous dental treatment? If so, what? _____ _____ _____ _____ _____ _____
____	____	17. Do you get a lot of headaches?
____	____	18. Does your jaw pop, click or grind when you open?
____	____	19. Do you smoke? If so, how much? _____
____	____	20. Is there anything that you would like to talk to the doctor privately about?
____	____	21. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Please explain: _____ _____ _____
____	____	22. Do you use any recreational drugs? i.e. marijuana, cocaine, etc.
____	____	23. Do you take any herbal medications? Please list _____ _____
____	____	24. Have you ever used Fen Fen?

Briefly explain the reason for your visit today.

PAYMENT: It is expected that payment for all treatment be made in full when treatment is performed.

INSURANCE: We consider each patient responsible for the entire account. As most insurance companies provide coverage from 50% to 80%, we require a minimum of 30% of the fee prior to the completion of your treatment. If your insurance payment is more or less, your account will be adjusted accordingly.

If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.

I wish to pay my account in the following manner:

_____ Cash _____ Check

_____ Visa _____ MasterCard

Signature of patient _____ Date _____

Parent or legal guardian if under 18 years of age _____

In Case of an Emergency, Please Contact:

Name *Address* *Phone #*

_____