WILSHIRE ORAL SURGERY AND IMPLANT CENTER

Today's Date

PATIENT INFORMATION:

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. First Name M.I. Last Name

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

Street Apt. City State Zip

Home Tel.( ) Cell.( ) Have you ever been a patient of our practice? ❏ Yes ❏ No

Referred By FIRST NAME LAST NAME Has a family member ever been a patient of our practice? ❏ Yes ❏ No

Dentist FIRST NAME LAST NAME Orthodontist FIRST NAME LAST NAME Medical Dr. FIRST NAME LAST NAME

Driver's Lic.# Nearest relative not living with you FIRST NAME LAST NAME Tel.( )

Employer Business Tel.( ) Extension

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

WHO WILL BE RESPONSIBLE FOR YOUR BILL:

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

Name FIRST NAME LAST NAME S.S.# Birth Date Age

Tel.( ) Cell. ( ) E-mail

Street Apt. City State Zip

Driver's Lic.# Employer Bus. Tel.( )

HOW DID YOU HEAR ABOUT OUR OFFICE:

❏ Dr. ❏ Patient ❏ Internet ❏ Magazine ❏ Mailer ❏ TV Commercial

❏ Radio ❏ Insurance ❏ Other

STATUS:

Student: . . . . . ❏ Full Time ❏ Part Time ❏ No. . . . . School Name and Address SCHOOL NAME ADDRESS

Marital Status: . ❏ Married ❏ Divorced ❏ Widow ❏ Single ❏ Legally Separated CITY STATE ZIP

Employed: . . . . ❏ Full Time ❏ Part Time ❏ Retired ❏ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer

Bus. Address ADDRESS CITY STATE ZIP

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address ADDRESS CITY STATE ZIP

Tel.( ) Group Name

Group # Insured Party FIRST NAME LAST NAME

Relation Birth Date Sex: ❏ M ❏ F

S.S. # Tel.( )

Address ADDRESS CITY STATE ZIP

PRIMARY MEDICAL INSURANCE COMPANY:

Employer

Bus. Address ADDRESS CITY STATE ZIP

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address ADDRESS CITY STATE ZIP

Tel.( ) Group Name

Group # Insured Party FIRST NAME LAST NAME

Relation Birth Date Sex: ❏ M ❏ F

S.S. # Tel.( )

Address ADDRESS CITY STATE ZIP

SECONDARY DENTAL INSURANCE COMPANY:

Employer

Bus. Address ADDRESS CITY STATE ZIP

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address ADDRESS CITY STATE ZIP

Tel.( ) Group Name

Group # Insured Party FIRST NAME LAST NAME

Relation Birth Date Sex: ❏ M ❏ F

S.S. # Tel.( )

Address ADDRESS CITY STATE ZIP

SECONDARY MEDICAL INSURANCE COMPANY:

Employer

Bus. Address ADDRESS CITY STATE ZIP

Bus. Tel.( ) Plan

Ins. Co. Name I.D. #

Address ADDRESS CITY STATE ZIP

Tel.( ) Group Name

Group # Insured Party FIRST NAME LAST NAME

Relation Birth Date Sex: ❏ M ❏ F

S.S. # Tel.( )

Address ADDRESS CITY STATE ZIP

HEALTH HISTORY:

Patient's Name ______________________

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 you ever had a serious / difficult problem associated with and previous dental work?	❑	❑
	If so, please explain ______________________		
3.	Have there been any changes in your general health in the past year?	❑	❑
4.	Are you under the care of a physician? . . . . ***Date of last visit*** ________ ***Tel. (*** ____ ***)*** ________	❑	❑
	If so, for what are you being treated? ______________________		
5.	Have you had any illness, operation or been hospitalized?	❑	❑
	If so, describe ______________________		
6.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where ______________________		
7.	Do you have a prosthetic joint / implant? . . . . ***If so, describe where*** ________	❑	❑
8.	Have you had a heart valve replacement or vascular graft?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Cancer / radiation therapy / chemotherapy?			
12. Are you now taking blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggronex, Pradaxa, Fish Oil, etc.)?			
13. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel IV–Zometa, Aredia, Xgeva, Prolia, Reclast, etc. in the past 12 years?			
14. Rheumatic fever?			
15. Damaged heart valves / mitral valve prolapse?			
16. Heart murmur?			
17. High blood pressure?			
18. Low blood pressure?			
19. Chest pain / angina?			
20. Heart attack(s)?			
21. Irregular heart rate / palpitations?			
22. Cardiac pacemaker?			
23. Heart surgery?			
24. Rheumatic heart disease?			
25. Coronary artery disease?			
26. Congenital heart disease?			
27. Pneumonia / bronchitis / chronic cough / COPD?			
28. Asthma?			
29. Hay fever / sinus problems?			
30. Snoring?			
31. Sleep apnea / CPAP?			
32. Difficult breathing / other lung trouble?			
33. Tuberculosis?			
34. Emphysema?			
35. Do you smoke or use chewing tobacco? If so, number of packs a day ________			
36. Blood transfusion?			
37. Blood disorder such as anemia?			
38. Bruise or bleed easily?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
39. Bleeding tendency / abnormal bleed?			
40. Hepatitis, jaundice, or liver disease?			
41. Infectious mononucleosis?			
42. Gallbladder trouble?			
43. Fainting spells / dizziness?			
44. Convulsions / epilepsy / seizures?			
45. Stroke?			
46. Thyroid trouble?			
47. Diabetes?			
48. Low blood sugar?			
49. Kidney trouble?			
50. High cholesterol?			
51. Are you on dialysis?			
52. Swollen ankles / arthritis / joint disease?			
53. Osteoporosis / osteopenia?			
54. Osteonecrosis?			
55. Stomach ulcers / acid reflux?			
56. Other gastrointestinal disease?			
57. Contagious diseases?			
58. Sexually transmitted diseases?			
59. HIV?			
60. Problems with immune system? Possibly from medication / surgery, etc.			
61. Delay in healing?			
62. A tumor or growth?			
63. Chronic fatigue / night sweats?			
64. Are you on a diet?			
65. A history of alcohol / drug abuse?			
66. Contact lenses?			
67. Eye disease / glaucoma?			
68. Mental health problems / anxiety / depression?			
69. Organ transplant?			
70. A removable dental appliance?			
71. Pain or clicking of jaws when eating?			

ARE YOU NOW TAKING:	YES	NO	NOTES
72. Any kind of medication, drug, pills?			
73. Antibiotics?			
74. Steroids, cortisone, prednisone, etc?			
75. Insulin or oral anti–diabetic drugs?			
76. Have you ever taken diet pills?			
77. Any natural product, herbal supplement or homeopathic remedy?			

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

79. Please list any medications you are currently taking:

Medication	Dosage	Frequency

Pharmacy Name: ______________________________

Location: ____________________ Tel.(_____) __________

Patient's Name ______________________________

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

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

WOMEN ONLY: *(QUESTIONS 99-103)*

99. Is there a possibility of pregnancy? . . . . ❑ **Y** ❑ **N**

100. Expected delivery date? ______________________

101. Date of last cycle?

102. Are you nursing? . . . . ❑ **Y** ❑ **N**

103. Are you taking birth control pills?. . . . . ❑ **Y** ❑ **N**

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.*

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

____

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 (______) ______________________

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 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**

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 through third-party finance companies. 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 any deductible amount, co-insurance or any other balance not paid for by your insurance company. Payment is due in full at the time of treatment.** You will be responsible for all collection costs, attorneys fees, and court costs.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________ **X** ____________

Signature of patient: *(Parent or Guardian if Minor)* **Date**

I hereby 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.

If you would like us to release your information to someone who may call on your behalf please list their name(s) below:

First Name ______________ Last Name ______________ Relation ______________

First Name ______________ Last Name ______________ Relation ______________

X ______________________________ **X** ____________

Signature of patient *(Parent or Guardian if Minor)* **Date**