Park Slope Oral & Maxillofacial Surgery Associates, LLP

PATIENT INFORMATION

□ Mr. □ Mrs. □ Ms. □ Dr. First Name_____ M.I._____ Last Name _____
Sex: □ M □ F Birth Date_____ Soc Sec#. _____ E-Mail_____
□ Single □ Married □ Divorced □ Widow □ Legally Separated □ Retired □ Student □ Minor □ Other
Home Address: _____ Apt# _____ City _____ State _____ Zip_____
Home Tel.(_____)_____Cell.(_____)_____Work. (_____) _____
Referred By_____General Dentist_____Orthodontist_____
Have you or any of your relatives been a patient of our practice? □ Yes □ No □ Don't Know
Emergency Contact_____ Tel. (_____) _____
Personal Payment Type: □ Cash □ Check □ Credit Card □ I wish to discuss office's payment policy
Who will be responsible for your account? □ Self □ Spouse □ Father □ Mother □ Other
Spouse or other guarantor information (if different from above)
Name_____ Relation_____ S.S# _____ Birth Date_____
Street_____City_____State_____ Zip _____
Tel. (_____)_____Employer_____Bus.Tel (_____)_____
Pharmacy Name: _____ Pharmacy Phone Number: (_____) _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____
Ins. Co. Name_____
Address_____
City_____ State _____
Zip_____ Tel. (____) _____
Subscribers Name _____
Relation □ Self □ Spouse □ Dependent
Group#_____ ID#_____
S.S. #_____ Birth Date_____

SECONDARY DENTAL INSURANCE

Employer _____
Ins. Co. Name_____
Address_____
City_____ State _____
Zip_____ Tel (____) _____
Subscribers Name _____
Relation □ Self □ Spouse □ Dependent
Group#_____ ID#_____
S.S.#_____ Birth Date _____

MEDICAL INSURANCE COMPANY

Employer_____ Bus. Tel. (_____) _____
Subscribers Name_____ID#_____
S.S.#_____ Birth Date _____
Ins. Comp. Name_____ Plan Type_____ Group No. _____
Ins. Address _____
Tel.(_____)_____Payer ID#_____

DENTAL HEALTH HISTORY

Reason for today's office visit _____
Do you have any sores or lumps in or near your mouth? □ Yes □ No
Have you ever had any difficulty or prolonged bleeding with previous extractions? □ Yes □ No

Do you smoke? □ Yes □ No If yes, _____ packs a day for _____ years
□ Bleeding Gums □ Loose teeth or broken fillings □ Clicking or popping jaw □ Sensitivity to hot or cold
□ Grinding teeth □ Frequently biting your lips or cheeks □ Difficulty in opening or closing your mouth
□ Dry mouth □ Bad breath □ Periodontal treatment □ Sensitivity to sweet or sour liquids

HEALTH HISTORY

Are you in good health? □ Yes □ No Have you had a heart valve replacement? □ Yes □ No
Have there been any changes in your general health in the past year? □ Yes □ No
Are you under the care of a physician? □ Yes □ No if so, for what are you being treated? _____
Do you have a prosthetic joint / implant? □ Yes □ No if so, describe where _____
Have you ever had a blood transfusion? □ Yes □ No Are you wearing contact lenses? □ Yes □ No

THIS SECTION IS FOR WOMEN ONLY

Is there a possibility of pregnancy? □ Yes □ No If so, expected delivery date_____
Are you nursing? □ Yes □ No Are you taking birth control pills? □ Yes □ No

MEDICATIONS

Are you taking or have you taken any of the following?

□ Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Bilova) □ Diet Pills □ Herbal Supplements
□ Bone Density medications / Bisphosphonates (Aredia, Zometa, Fosomax, Actonel) □ Sleeping Pills
□ Anti Depressants / Tranquilizers on a regular basis □ Controlled substances
Others_____

ALLERGIES

□ Local Anesthetic (Lidocaine) □ Penicillin □ Other antibiotics □ Sulfa □ Tranquilizers/ Sedatives (Valium)
□ Aspirin □ Codeine or other narcotics □ Iodine □ Metals □ Latex □ Other medications _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

□ ADD/ADHD □ Anemia □ Angina □ Arthritis, Rheumatism □ Artificial Heart Valves □ Artificial Joints □ Asthma
□ Back Problem □ Bronchitis □ Cancer □ Cardiac Pacemaker □ Chemical Dependency □ Chemotherapy □ Chest Pain
□ Chronic Fatigue □ Circulatory Problems □ Contagious diseases □ Cortisone Treatment □ Diabetes □ Difficulty Breathing
□ Epilepsy □ Emphysema □ Fainting Episodes□ Gallbladder Trouble □ Glaucoma □ Gout □ Heart Attack □ Heart Disease
□ Hemophilia □ Hepatitis □ High Blood Pressure □ HIV+ /AIDS □ Hay Fever □ Kidney Disease □ Lung Problems
□ Leukemia □ Liver Disease □ Low Blood Pressure □ MVP □ Radiation Treatment □ Respiratory Disease □ Scarlet Fever
□ Skin Conditions □ Stroke □ Swollen Ankles □ Thyroid Problems □ TMJ □ Tuberculosis □ Ulcers □ Venereal Disease
□ History of Alcohol Abuse □ History of Drug Abuse □ Mental Health Problems
□ Other_____

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 certify to the best of my knowledge, the information I have provided on this form is complete and correct. I will not hold my surgeon, or any other member of his/ her staff, responsible for any errors or omissions that I have made in the completion of this form.
Signature of patient:X_____Date:_____

Dental insurance is intended to cover some, but not all of the cost of your treatment. Most plans include deductibles and co-payments, which must be paid by the patient at the time services, are rendered. I accept responsibility for the entire amount of the bill and agree to pay the unpaid portion that my insurance does not cover.
Signature of patient:X_____Date:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 questions I may have regarding this notice.

X_____Date_____

HHRB:_____

DATE:_____