



Park Slope Oral & Maxillofacial Surgery

PATIENT INFORMATION:

TODAY'S DATE _____

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

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 COMPAN

SECONDARY DENTAL INSURANCE COMPANY

Insurance Name _____

Insurance Name _____

Insurance Address _____

Insurance Address _____

Subscribers Name _____

Subscribers Name _____

Employer: _____

Employer: _____

Relation to Patient Self Spouse Dependent

Relation to Patient Self Spouse Dependent

Group # _____ ID# _____

Group # _____ ID# _____

S.S. # _____ Birth Date _____

S.S. # _____ Birth Date _____

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

Difficulty in opening or closing your mouth Yes No

Bleeding Gums Yes No Dry mouth Yes No

Loose teeth or broken filling Yes No Bad breath Yes No

Clicking or popping jaw Yes No Periodontal treatment Yes No

Sensitivity to hot or cold Yes No Sensitivity to sweet or sour liquids Yes No

Grinding teeth Yes No Frequently biting your lips or cheeks Yes No

HEALTH HISTORY

Are you in good health? Yes No

Have you had (HVP) 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:

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

ALLERGIES:

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

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

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

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.

Signature of patient: X _____ Date: ____/____/____

Office use only

HHRB: _____ Date: ____/____/____ Dr. Chionchio Dr. Sengupta