ORAL AND MAXILLO-FACIAL SURGERY, INC.

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Date _____ Patient's Name _____ Update _____
E-mail Address _____ Age _____ Date of Birth _____
Mailing Address _____
_____
(City) (State) (Zip)
Home Phone _____ Cell Phone _____ Work Phone _____
Single ❑ Widow ❑ Married ❑ Husband/Wife's Name _____
If Child Parent's Names _____
If Child, Parent's Mailing Address _____
_____
(City) (State) (Zip)
Social Security # _____ Patient Employed By _____
In Case of Emergency Contact _____ Home/Cell Phone _____Work _____
If Child, Parents Employed By _____ Phone # _____
Have you ever been a patient in our office before? _____
Who may we thank for referring you? _____
Chief Complaint (why are you here to see us today) _____
My **Physician** is: _____ My **Dentist** is: _____

The following medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction, or a major oral surgical procedure. Your general health may have significant effect on your current condition and the outcome of any proposed treatment. For the sake of your overall health and safety, please be complete in your answers.

Have You Ever Had?

Yes No

- ❑ ❑ Heart Murmur/Abnormal Heart Sound
- ❑ ❑ Irregular Heart Beat
- ❑ ❑ Rheumatic Fever/Rheumatic Heart Sound
- ❑ ❑ Heart Disease/Heart Attack
- ❑ ❑ Heart Surgery/Heart Valve
- ❑ ❑ Lung Trouble/TB/+PPD
- ❑ ❑ Shortness of Breath
- ❑ ❑ Swelling of Ankles
- ❑ ❑ Anemia/Sickle Cell Disease
- ❑ ❑ High or Low Blood Pressure
- ❑ ❑ Bleeding Problems/Bleed or Bruise easily
- ❑ ❑ Cerebrovascular Disease (Stroke/TIA)
- ❑ ❑ Prosthetic Joint Surgery (artificial-knees, hips, etc.)
- ❑ ❑ Jaundice or Liver Disease/Hepatitis
- ❑ ❑ Convulsions/Seizures/Epilepsy
- ❑ ❑ Dizziness/Fainting
- ❑ ❑ Diabetes
- ❑ ❑ Kidney Disease
- ❑ ❑ Painful Joints
- ❑ ❑ Pain in Chest
- ❑ ❑ Pain in Arms
- ❑ ❑ Arthritis

Yes No

- ❑ ❑ Osteoporosis
- ❑ ❑ Asthma/Bronchitis/Pneumonia
- ❑ ❑ Herpes
- ❑ ❑ AIDS
- ❑ ❑ Sexually related illnesses
- ❑ ❑ HIV
- ❑ ❑ A.C.T.H./Cortisone/Steroids
- ❑ ❑ Blood Transfusion/Been told you cannot donate blood
- ❑ ❑ Ulcers
- ❑ ❑ Thyroid Disease
- ❑ ❑ Sinus Problems
- ❑ ❑ Glaucoma
- ❑ ❑ Tumor/Cancer/Radiation Treatment/Chemotherapy
- ❑ ❑ Immune System Compromise/Frequent infections
- ❑ ❑ Anxiety/Depression/Psychiatric Illness Requiring Treatment by a psychiatrist/Psychologist

Have you Ever Had Allergies to:

Yes No		**Yes No**	
❑	❑ Penicillin	❑	❑ Any Foods
❑	❑ Aspirin	❑	❑ Anesthetics, like Novocaine
❑	❑ Codeine	❑	❑ Latex gloves, etc.
❑	❑ Demerol	❑	❑ Other Drugs- List:_____

_____

Are you seeing any specialist doctors now (Cardiologist/Hematologist, ect.)? Yes ❑ No❑

Why _____

When was your last **physical** examination? _____ Was anything **unusual** or abnormal found? _____

If yes, please explain _____

Are you now under the active care of a physician for any reason: Yes ❑ No ❑

If yes, please explain _____

Are you or have you recently been taking **drugs** or **medications**? Yes ❑ No ❑

If yes, please list: _____

Do you take any medicine for **osteoporosis** (to prevent **bone loss**) such as Fosamax, Actonel, Didronel, ect.? Yes ❑ No ❑

Have you had any surgery in the past? Yes❑ No ❑

If yes, please explain _____

Have you had General Anesthesia before? Yes ❑ No❑ I.V. Sedation Yes ❑ No❑

Have you or a member of your family ever had difficulty with, or bad reaction to, General Anesthesia? Yes ❑ No ❑

If yes, please explain _____

Do you have a cold or cough at this time? Yes ❑ No ❑

Do you **smoke**? Yes ❑ No ❑ If yes, how many? _____

Do you use any of the following**:** **Chewing tobacco** Yes ❑ No❑ **Marijuana** Yes ❑ No ❑ **Drugs** Yes ❑ No ❑

Do you have any disability? Yes ❑ No❑

If yes, please explain _____

Height _____ How much do you weigh? (for dosage of medicines only) _____

Please explain any medical conditions of which we should be aware _____

_____

Female Patients: Are you, or could you be, pregnant? Yes ❑ No ❑

Are you nursing? Yes ❑ No ❑

Are you taking birth control pills? Yes ❑ No❑

_____

Patient's Signature Date Parent/Guardian (if minor)

MEDICAL HISTORY UPDATE

Have there been any changes in your health since you last reviewed this form? Yes ❑ No ❑

If yes, for what conditions? _____

Are you taking any new medications? Yes ❑ No ❑

If so, what? _____

_____

Patient's Signature Date Parent/Guardian (if minor)

INSURANCE INFORMATION

Subscriber's Social Security # _____

Student Status
❑ Full Time ❑ Part Time School Name _____

Primary Dental Ins. Company Name:_____
Subscriber's Name _____
Subscriber's Identification # _____
Group # _____
Subscriber's Birthdate _____
Subscriber's relationship to patient _____

Primary Medical Ins. Company Name: _____
Subscriber's Name _____
Subscriber's Identification # _____
Group # _____
Subscriber's Birthdate _____
Subscriber's relationship to patient _____

Secondary Dental Ins. Company Name: _____
Subscriber's Name _____
Subscriber's Identification # _____
Group # _____
Subscriber's Birthdate _____
Subscriber's relationship to patient _____

Secondary Medical Ins. Company Name_____
Subscriber's Name _____
Subscriber's Identification # _____
Group # _____
Subscriber's Birthdate _____
Subscriber's relationship to patient _____

Who is responsible for any bills/Refunds?
Name**:**_____
Mailing Address: _____
_____
(City) (State) (Zip)
Home Phone:_____ Cell Phone: _____

AUTHORIZATION

I hereby authorize Dr. Harold J Haney to release information requested by my insurance company or workman's compensation carrier.
I also authorize Dr. Haney to release information to any hospital or physician I may be referred to by this office.
I hereby authorize assignment and payment directly to Dr. Harold J. Haney benefits due me.

Signature of patient: (Parent or Guardian if minor) _____ Date _____

FEES and PAYMENTS

Our primary mission is to deliver the best and most comprehensive oral surgery care available. An important part of the mission is making the cost of optimal care as easy and affordable as possible. We offer several payment options to choose from: cash, check, all major credit cards as well as Care Credit; an interest free private financing company.

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. An estimate of the charge for any procedure or surgery you may require will be given to you. **Insurance estimates given are not a guarantee of payment.** Once your claim is submitted to your insurance you are responsible for any outstanding balances. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute payment. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

I HEREBY AGREE TO PAY ANY AND ALL CHARGES INCURRED, INCLUDING THOSE NOT COVERED BY INSURANCE

Signature of patient: (Parent of Guardian if minor) _____ Date _____