Parkside Oral Surgery & Implant Center

Today's Date 09/01/2021

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ E-Mail _____

If a family member has ever been a patient of our practice, please indicate name and relation _____

Dentist: Dr. _____ (LAST NAME) Orthodontist: Dr. _____ (LAST NAME) Primary Care: Dr. _____ (LAST NAME)

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

Who is filling out this form: ❑ Self ❑ Parent / Guardian (name) _____ ❑ Power of Attorney (name) _____

Whom are we allowed to speak to regarding your health, besides you (for example, your spouse, partner, sibling(s), children, etc.):

Please list name and relation

Preferred Pharmacy Name _____

Pharmacy Address _____ City _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip to the next section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____ Relation _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

❑ **I have NO Dental Insurance, and will pay out of pocket at time of service**.

PRIMARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # _____

Group Name _____

Group # _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____

PRIMARY MEDICAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # _____

Group Name _____

Group # _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____

SECONDARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # _____

Group Name _____

Group # _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____

SECONDARY MEDICAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # _____

Group Name _____

Group # _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____

HEALTH HISTORY:

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 there been any changes in your general health in the past year?	❑	❑
3.	Are you under routine care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Have you had recent exposure to any Aerosol Transmissible Diseases (ATDs), such as SARS, mumps, Pertussis (whooping cough), Meningitis, Pneumonia, Coronavirus (COVID-19)?	❑	❑
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 ever had general anesthesia?	❑	❑
10.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
11.	Has a physician or a surgeon recommended that you take antibiotics prior to your dental treatment?	❑	❑

DO ANY OF THESE CONDITIONS APPLY TO YOU:	YES	NOTES
12. Congenital (from birth) heart disease		
13. High blood pressure		
14. Congestive heart disease		
15. Heart attack		
16. Chest pain / angina / coronary artery disease		
17. Irregular heart beat		
18. Stroke / TIA		
19. Asthma		
20. Lung disease (emphysema, COPD, shortness of breath)		
21. Liver disease		
22. Bleeding disorder Please specify _____		
23. Kidney disease Please specify _____		
24. Are you on dialysis Which days _____		
25. Diabetes Recent H_bA_1c level _____		
26. Thyroid disease		
27. Stomach ulcers / colitis Please specify _____		
28. Clicking or popping of jaw joint / pain near the ear / difficulty opening the mouth		

DO ANY OF THESE CONDITIONS APPLY TO YOU:	YES	NOTES
29. Rheumatoid arthritis		
30. Osteoporosis / osteopenia		
31. Chronic sinus / nasal problems		
32. Neurologic disorder (dementia, Alzheimer's, Parkinson's, brain injury, cerebral palsy, migraine) Please specify _____		
33. Seizure disorder		
34. Vertigo		
35. Developmental disorder (autism, ADHD)		
36. Mental health problems (anxiety, bipolar, depression, PTSD)		
37. Eye disease (glaucoma / macular degeneration)		
38. Cancer Please specify _____		
39. Radiation and / or chemotherapy treatment for cancer		
40. Depressed immune system (HIV, cancer therapy, transplant patient, autoimmune disorder)		
41. Smoking or chewing tobacco How much per day _____		
42. Sleep apnea on CPAP machine / oral appliance		
43. Do you use marijuana or cannabis products? Please specify		

		Yes	No
44.	Have you had any serious problems associated with any previous dental / surgical treatment?	❑	❑
	If so, please explain _____		
45.	Is there any past history of alcohol or chemical dependency or emotional / psychological difficulties that may affect the care we give you?	❑	❑
46.	Do you take tranquilizers, sleeping pills, anti-depressants, and / or narcotics on a regular basis?	❑	❑
47.	Are you under the care of a physician for pain management, or for recovering from drug or alcohol addiction?	❑	❑
	If so, please specify the treating physician's name _____		
48.	Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?	❑	❑
	If so, please explain _____		
49.	Is there a family history of ❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems		

ARE YOU CURRENTLY TAKING:	YES	NOTES
50. Antibiotics		
51. Blood thinners (Coumadin, Plavix, Aggrenox, Pradaxa)		
52. OTC anti-inflammatory medications (aspirin, Motrin, Advil, Aleve, ibuprofen)		
53. High blood pressure medication		
54. Digoxin, Nitroglycerin or other heart drugs		
55. Insulin or oral anti-diabetic drugs		
56. Prolonged steroid (Cortisone, Prednisone) treatment		
57. Bone density medications, such as RANKL inhibitors or bisphosphonates (Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista) in the past 12 years		
58. Have you ever been advised NOT to take a medication? Please specify: _____		

59. Please list any medications you are currently taking:

Medication	Dosage	Frequency

ALLERGIES OR DRUG REACTION TO:	YES	NOTES
60. I have no known drug allergies / reactions.		
61. Local anesthetic (numbing meds)		
62. Penicillin / Amoxicillin		
63. Cephalosporin (Keflex)		
64. Sulfa drugs (Bactrim, Septra)		
65. Sedatives / tranquilizers		
66. Aspirin / ibuprofen		
67. Narcotic pain killers (Codeine, Hydrocodone, Oxycodone)		
68. Latex or rubber products		

69. Please list any other allergies:

WOMEN ONLY: *(QUESTIONS 70–71)*

	Yes	No
70. Are you pregnant, or is there a chance you might be? . .	❑	❑
71. Are you nursing?	❑	❑

Note: *Are you currently taking Birth Control Pills? If you are using ORAL CONTRACEPTIVES, it is important that you understand that medications such as antibiotics may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.*

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE THE DOCTOR TO KNOW:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

❑ **YES –** *"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."*

TELEPHONE AND TEXT MESSAGES

Patient privacy policy prevents us from leaving medically-related messages on your voicemail/answering system and/or via text messages unless you authorize us to do so.

❑ **YES –** *"I authorize the office of Parkside Oral Surgery & Implant Center to leave messages on the answering device indicated on the "Patient Information" section and/or text messages to the cell number. I understand that the information contained in the message may concern appointment dates, test results, laboratory studies or general physical information. I further understand that the saved message may not be secure or private."*

TELEHEALTH CONSULTATION SERVICES CONSENT

❑ **YES –** *"I acknowledge that a copy of the Telehealth Consultation Services Consent has been provided to me. I have read and understood the risks associated with telehealth consultation as described. All my questions regarding this consent have been answered to my satisfaction. I authorize the use of telehealth instead of an in-office consultation."*

COVID-19 CONSENT

❑ **YES –** *"I hereby certify that I have read the COVID-19 Consent Form and understand and accept the risks as described."*

❑ **YES** ❑ **NO –** *"I have read the COVID-19 - Patient Wellness Form. I hereby confirm that all the questions pertaining to recent exposure to COVID-19 and having signs or symptoms associated with the COVID virus are answered "NO". I will report any changes to the office prior to my appointment."*

FEES AND PAYMENTS

We make every effort to minimize the cost of your care. You can help by paying upon completion of each visit. Payment arrangements can be made with our office manager depending upon special circumstances. 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.** You will be responsible for all collection costs, attorney fees, and court costs.

❑ **YES – "***I understand and agree to the above statement. Any and all fees incurred in the office will be my responsibility."*

AUTHORIZATION

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 surgeon, or any other member of her staff, responsible for any errors or omissions that I have made in the completion of this form.

I authorize my surgeon and her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X _____ **X** _____

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