Health Questionnaire

Today's Date:____/____/____

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Patient's Name:_______________________________
How would you like to be addressed? ____________ Social Sec. #:______________ Birth Date:____/____/____
Street Address:____________________ Apt./P.O. Box:_____ City:______________ State:____ ZIP:________
Home Phone: ________________ Cell/Text #: __________________ Work #: ______________
E-mail:______________________ How would you prefer to be contacted? ☐ Home Phone ☐ Cell ☐ Text Msg
Age:_____ M / F Height:_____ Weight: ______ Marital Status: __________
Place of Employment:__________________________ Occupation:______________________
Student: ☐ Full Time ☐ Part Time School: ______________________________
Dentist's Name:_______________ Orthodontist:_________________ Physician: ______________
Date of Last Visit to Physician:__________ Reason:______________________________________
Have you ever been a patient in our office? ☐ Yes ☐ No If yes, when? ______________
Has a family member ever been a patient of our practice? ☐ Yes ☐ No If yes, when?__________________
Who referred you to our office?__________________
Emergency Contact Name:__________________ Relation:____________ Phone: ______________

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your body and will reflect your overall health. Problems you may have, or medications you are taking could have an important relationship with the care that we will be providing. We appreciate your taking the time to answer the questions. Your answers will be completely confidential, and only used for our records.

Reason for coming to our office today?____

Health History

Question	YES	NO
Have there been any changes in your health this past year? If yes, please describe:____________	☐	☐
Have you had any illness, operation, or been hospitalized in the past two years? Please describe:	☐	☐
Are you currently under the care of a physician? Please describe:____________	☐	☐
Have you ever had cancer? If yes, please list type and treatment:____________	☐	☐
Do you have any unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? If yes, please describe where:____________	☐	☐
Have you or a close family member had any unusual or serious reactions to general anesthesia? If yes, please explain:____________	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
Is this visit related to an accident? Please list date of accident:____/____/____ Please describe accident:	☐	☐
Do you wish to speak to the Doctor privately about anything?	☐	☐

Women Only

☐ Are you pregnant at this time? If yes, how many months?______
☐ Are you nursing?
☐ Are you taking birth control pills?

Please continue to Page 2 of 2

Health Questionnaire (cont'd.)

Health History (Continued)

Are you allergic to anything? Penicillin, Drugs, Medications, Soy, Eggs? Please list:____________________

Have you ever had any other adverse drug reactions? Please list:____________________

Have you ever taken cortisone or other steroid drugs?Please list:____________________

Have you ever had radiation to your head or jaws? Please explain:____________________

Do you currently have a fever? Please explain:____________________

Do you currently have difficulty breathing? Please explain:____________________

Have you travelled internationally in the last 10 days?____________________

Have you taken the weight loss drugs Fen-Phen, Pondiminn or Redux?:____________________

Have you used any recreational, illegal, or "street" drugs (Marijuana, cocaine, etc.) in the past 12 months?:____________________

Have you ever experienced jaw joint (TMJ) pain, clicking,popping, grating, limited mouth opening or difficulty chewing?

____

Are you currently or have you in the past taken bisphosphonates? (Bone density medication: Actonel,Fosamax, Boniva, Zometa, etc.)____________________

Please Check Yes Or No

	YES	NO	NOTES
Heart Trouble			
Heart Attack			
Chest Pain			
High Blood Pressure			
Heart Murmur			
Rheumatic Fever			
Hearing Impairment			
Sleep Apnea			
Sinus Problems			
Fainting			
Stroke			
Tuberculosis			
Kidney Condition			
Psychiatric Treatment			
Stomach Trouble			
Asthma, Emphysema			
Breathing Problems			
Hepatitis, Jaundice, Liver disease			
Glaucoma			

Please Check Yes Or No

	YES	NO	NOTES
Eating Disorders			
Porphyria			
Anemia			
Diabetes			
Epilepsy, Convulsions			
Excessive Bleeding			
Immune Deficiency			
Artifical Joint/Valve			
Prosthetic Joint/Implant			
Do you smoke?			
Please note packs per day			
How many years?			
Do you have a smoker's cough?			
Are you a former smoker?			
If yes, how many packs per day?			
How many years did you smoke?			
When did you quit?			
Do you have an Advance Directive/ DNR ("Do Not Resuscitate" Order)?			

Current Medications

Please list any Medications that you are currently taking, Dosage, and Frequency:____________________

____

____

____

____

Prior To Surgery

Who will drive you home after surgery? ____________________ Relation:____________________

Do you wear contact lenses? ____________Dentures?__________

The day of surgery: Have you had anything to eat or drink in the last 6 hours?____________________

Do you have any other information that you think we should know about?____________________

____

____

I certify that the above information is complete and accurate.

____________________ _____/_____/_____

Signature of Patient, Parent, or Guardian Date

____

Printed Name

Insurance Policy & Financial Agreement

Patient Name:______________________________ Today's Date:____/____/____

Medical Insurance

Medical Insurance Co.:______________________________ Phone #:____________________

Medical Insurance Co. Address:____

ID#:____________________ SS#:____________________ Group/Plan #:____________________

Name of Insured:______________________________ Date of Birth:____/____/____

Insured Address:______________________________ City:______________ State:________ ZIP:________

Insured Home Phone:____________________ Cell#:____________________ Work #:____________________

Insured Place of Employment:______________________________ Occupation:____________________

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Dental Insurance

Dental Insurance Co.:______________________________ Phone #:____________________

Dental Insurance Co. Address:____

ID#:____________________ SS#:____________________ Group/Plan #:____________________

Name of Insured:______________________________ Date of Birth:____/____/____

Insured Address:______________________________ City:______________ State:________ ZIP:________

Insured Home Phone:____________________ Cell#:____________________ Work #:____________________

Insured Place of Employment:______________________________ Occupation:____________________

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

Do you have any additional insurance? Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Is this a Workman's Compensation? ☐ Yes ☐ No

If yes, please inform our front desk personnel with this information.

OMS is an independent practice. We will file all insurance claims on your behalf the day of service and insurance predeterminations can be filed upon request. However, the insurance contract is between the patient and the insurance company. If you have any questions regarding your insurance coverage, deductions, or exclusions you should contact your insurance company directly. To obtain fees prior to surgery, please inform us to schedule an appointment for a consultation. Typically healthcare providers do not become involved in any dispute of denial or settlement issues. Letters of protection from an attorney do not substitute for a payment plan.

OMS has my permission to obtain or release any insurance information on my behalf to help determine the extent of my medical/dental insurance coverage. I understand that OMS is not responsible for interpreting the extent of my insurance coverage nor for any possible misinterpretation by the insurance carrier in determining benefits.

I certify that the above information is complete and accurate.

The guarantor is responsible for all fees, regardless of insurance coverage. I understand that I am fully responsible for all fees, including any amount not covered by insurance. Parents who bring in children and sign as the responsible party will be held responsible for the fees. Balance is due 90 days from the date of service. After 90 days, interest will be assessed at the rate of 1% per month as a late payment fee on the unpaid balance.

X______________________________ ____/____/____

Signature of Person Financially Responsible for Patient (Patient, Parent or Guardian) Date

X______________________________

Printed Name

HIPAA Patient Communication

Consent for Use & Disclosure of Confidential Health Information

Patient Name:____Today's Date:____/____/____

Date of Birth:_____/_____/_____ Medical Record Number:__________________________

As part of your health care, OMS maintains records describing health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. By signing this form, you are consenting to OMS's use and disclosure of your protected health information to carry out treatment, payment, or health care operations. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

If you do not agree to sign this form, OMS may refuse to treat you.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of the Notice. Any new Notice provisions will be effective for all protected health information that we maintain. Should you wish to obtain a revised Notice, you may call our office and ask to speak to our Privacy Officer.

You have the right to request that OMS restrict how we use and disclose your protected health information. We are not required to agree to such restrictions, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclosure to the extent we document such in writing and notify you of same.

You have the right to revoke this consent in writing at any time, except to the extent that OMS has acted in reliance on it.

With whom may we discuss clinical or financial information?

____

I understand and agree to the information above:

X_______________________________________ _____/_____/_____

Signature of patient or legal representative of the patient Date

____

If legal representative, state relationship to patient

____

Printed Name

Consent for Permanent Records

I, ____, hereby grant permission to Dr. ________________________________ to obtain permanent records in the form of study models (casts), radiographs, photographs, and video recordings as required for diagnosis, treatment planning and post-treatment evaluation. These records will benefit planning, treatment and progress assessment, as well as provide knowledge to improve future patient care. No appreciable risk, stress or discomfort will result from the record-taking procedures.

I understand that I am free to ask questions about the procedures before as well as after consenting, that my participation is voluntary, and that withdrawal is possible at any time. My permission is granted to use the records for publication in scientific and professional journals and presentations with the understanding that my identity will remain confidential.

X____ ______/______/______
Signature (Parent or Guardian if minor) Date