QUINCY MEDICAL GROUP
Oral and Maxillofacial Surgery

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PATIENT INFORMATION:

Today's Date _____

Patient's Name _____ (FIRST NAME / M.I. / LAST NAME) Date of Birth _____ Age _____ Sex: ❑ Male ❑ Female

Mailing Address _____ City _____ State _____ Zip _____

Patient SS # _____ Home Phone ( ) _____ Cell Phone ( ) _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Spouse's Name _____ (FIRST NAME / LAST NAME)

E-Mail Address _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Employer _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Dentist _____ (FIRST NAME / LAST NAME) Doctor _____ (FIRST NAME / LAST NAME) Referred By _____ (FIRST NAME / LAST NAME)

PLEASE NOTE: THE PARENT / GUARDIAN ACCOMPANYING MINORS WILL BE RESPONSIBLE FOR PAYMENT

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Responsible Party Name _____ (FIRST NAME / LAST NAME) Date of Birth _____ Sex: ❑ Male ❑ Female

Address _____ City _____ State _____ Zip _____

SS # _____ Home Phone ( ) _____ Cell Phone ( ) _____

Employer _____ Work Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION:

Dental Insurance Company _____ Policy Holder Name _____ (FIRST NAME / LAST NAME)

Policy Holder Date of Birth _____ Policy Number _____

Medical Insurance Company _____ Policy Holder Name _____ (FIRST NAME / LAST NAME)

Policy Holder Date of Birth _____ Policy Number _____

PLEASE BE SURE TO PROVIDE YOUR INSURANCE CARDS AND DRIVER'S LICENSE AT THE TIME OF CHECK-IN

I have provided the demographic information on this form and certify that I am the patient or the legal guardian of the patient.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

Patient Name _____ Date of Birth _____

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 the 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.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? *If so, describe where* _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
10. Rheumatic fever?			
11. Damaged heart valves / mitral valve prolapse?			
12. Heart murmur?			
13. High blood pressure?			
14. Low blood pressure?			
15. Chest pain / angina?			
16. Heart attack(s)?			
17. Irregular heart beat?			
18. Cardiac pacemaker?			
19. Heart surgery?			
20. Pneumonia, bronchitis, chronic cough?			
21. Asthma?			
22. Hay fever / sinus problems?			
23. Snoring / sleep apnea?			
24. Difficult breathing / other lung trouble?			
25. Tuberculosis?			
26. Emphysema?			
27. Do you smoke? If so, number of packs a day _____			
28. Do you use chewing tobacco?			
29. Blood transfusion?			
30. Blood disorder such as anemia?			
31. Bruise easily?			
32. Bleeding tendency / abnormal bleed?			
33. Hepatitis, jaundice, or liver disease?			
34. Infectious mononucleosis?			
35. Gallbladder trouble?			
36. Fainting spells?			
37. Convulsions / epilepsy?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Stroke?			
39. Thyroid trouble?			
40. Diabetes?			
41. Low blood sugar?			
42. Kidney trouble?			
43. High cholesterol?			
44. Are you on dialysis?			
45. Swollen ankles / arthritis / joint disease?			
46. Osteoporosis / osteopenia?			
47. Osteonecrosis?			
48. Stomach ulcers / acid reflux?			
49. Contagious diseases?			
50. Sexually transmitted diseases?			
51. Problems with immune system? Possibly from medication / surgery, etc.			
52. Delay in healing?			
53. A tumor or growth?			
54. Cancer / radiation therapy / chemotherapy?			
55. Chronic fatigue / night sweats?			
56. Are you on a diet?			
57. A history of alcohol abuse?			
58. A history of drug abuse?			
59. Contact lenses?			
60. Eye disease / glaucoma?			
61. Mental health problems / anxiety / depression?			
62. A removable dental appliance?			
63. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 64–67)*

		Yes	No
64.	Is there a possibility of pregnancy?	❑	❑
65.	Expected delivery date? _____		
66.	Are you nursing?	❑	❑
67.	Are you taking birth control pills?	❑	❑

Note: *Antibiotics may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

Patient Name _____ Date of Birth _____

ARE YOU NOW TAKING:	YES	NO	NOTES
68. Any kind of medication, drug, pills?			
69. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?			
70. Have you ever taken diet pills?			
71. Any natural product, herbal supplement or homeopathic remedy?			
72. Are you taking, or have you ever taken, bone density meds. or bisphosphonates such as Fosamax, Boniva, Actonel, IV– Zometa, Aredia, or Reclast in the past 12 years?			
73. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:			
74. Please list any medications you are currently taking: Medication | Dosage | Frequency | Medication | Dosage | Frequency			

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
75. Local anesthetic (numbing meds.)?			
76. Penicillin?			
77. Other antibiotics?			
78. Sulfa drugs?			
79. Sodium pentothal / Valium / other tranquilizers?			
80. Aspirin?			
81. Amoxicillin?			
82. Codeine or other narcotics?			
83. Other medications?			
84. Latex?			
85. Soy?			
86. Eggs / yolk?			
87. Sulfites?			
88. Do you have any known allergies?			
89. Please list any allergies other than drug allergies:			

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

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

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date** X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other 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 g iven 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 informat ion 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, attorneys fees, and court costs.

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

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize p ayment to this doctor named of the benefits otherwise payable to me.

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

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of dia gnosis and treatment planning. Furthermore, I authorize the taking of all 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 _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Witness** X _____ **Doctor** X _____ **Date**

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.

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

PROGRESS NOTES