Patient Information
- CONFIDENTIAL –

Today's Date:_____

Patient Personal Information

Name: _____ Sex: Male ☐ Female ☐

Address:_____Apt./Lot #: _____

City: _____ State: _____ Zip:_____

We use both your cell phone and e-mail to confirm your appointments, ***Opt In*** ☐ ***Opt Out*** ☐

"Message & data rates may apply"

Cell Phone: ( )_____-_____Email: _____

Soc. Sec. #: _____-_____-_____Birth date:_____ Age:_____

Person to contact in case of emergency:_____Phone: ( )_____-_____

If Patient is a minor, Responsible party information:

Name: _____ Sex: Male ☐ Female ☐

Address:_____ Apt or Lot #: _____

City:_____State:_____ Zip: _____

Insurance Information - Primary Holder Information:

Name of *person insured*:_____Relationship to Patient: _____or Self

Birth Date: _____Social Security #: _____

Address of *Person Insured* if different: _____

Insurance Company: _____Medicaid #: _____

Employer Name:_____

Employer Address:_____

City:_____State:_____Zip:_____

Do you have any additional Insurance? YES ☐ **NO** ☐ **If yes, complete the following:**

Name of *person insured*:_____Relationship to Patient: _____

Address of *Person Insured* if different: _____

Birth date: _____Social Security #: _____

Name of Employer:_____Work Phone: _____

Employer Address:_____

City:_____State:_____Zip:_____

Insurance Company: _____ Medicaid #: _____

Patient Medical/Dental History

Referring Office Name: _____ Doctor Name: _____ Office Phone: _____

Medical Information

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any Surgical operation or serious illness?	☐	☐
If yes, please explain		
3. Are you taking any medication(s), including any non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking?		
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use Marijuana?	☐	☐
6. Do you use tobacco?	☐	☐
7. Do you have history of drug use?	☐	☐
8. Do you have history of alcoholism?	☐	☐

Allergy Information

1. Are you allergic to or have you had any reactions to any of the following?

	Yes	No
- Local Anesthetic (e.g. Novocain)	☐	☐
- Penicillin or other Antibiotics	☐	☐
- Sulfa Drugs	☐	☐
- Barbiturates	☐	☐
- Sedatives	☐	☐
- Iodine	☐	☐
- Aspirin, Motrin, Aleve or Ibuprofen	☐	☐
- Any Metals (e.g. nickel, mercury, etc.)	☐	☐
- Latex Rubber	☐	☐
- Other (please list)	☐	☐

2. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Antibiotics may stop the effectiveness of Birth Control Pills

Medical History

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Stroke	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Hay Fever/Allergies	☐	☐
Swelling of limbs	☐	☐	Angina	☐	☐	Tuberculosis	☐	☐
Fainting/Seizures	☐	☐	Autism	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Glaucoma	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Recent Weight Loss	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Liver Disease	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Breathing Problems	☐	☐
Kidney Diseases	☐	☐	Joint Implant	☐	☐	Mitral Valve Prolapse	☐	☐
AIDS or HIV	☐	☐	Hepatitis/Jaundice	☐	☐	Sleep Apnea	☐	☐
Thyroid Problem	☐	☐	Sexually Transmitted Diseases	☐	☐	Blood Diseases/coagulation disorder	☐	☐
Malignant Hyperthermia	☐	☐	Sickle Cell Anemia	☐	☐	Osteoporosis Medication	☐	☐
Fibromyalgia	☐	☐	Other	☐	☐	Psychiatric Problems	☐	☐

Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Have you had any adverse effects from dental treatment?	☐	☐
If Yes, please explain?		

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the oral surgeon to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health/dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if minor)

Doctor Comments_____ Revision 09

Financial Policy & Notice of Privacy Practices

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship.

We must emphasize that as a health care provider, our relationship is with *you*, not with your insurance company.

- Your insurance is a contract between you, your employer and the insurance company.
- Phone and written confirmation of your co-pay is not necessarily a guarantee of payment.
- Required co-payments must be made on the Due-date given by our office.
- **YOUR CO-PAY IS ONLY AN ESTIMATE. You are responsible for balance not paid by your insurance company.**

Payment for services is due at the time service is rendered, unless payment arrangements have been approved in advance by our office. You are responsible for timely payment of your account.

Late payments will be subject to a 24% APR late fee. If applicable, you will be responsible for any lawyer and/or Collection Agency expenses that may be incurred. All discounts given will be revoked if payment/balance is not paid by the due date.

I have read the above information; I understand and agree that I am responsible for the payment of all professional services rendered.

Acknowledgement of Receipt of Notice of Privacy Practices

I am aware of this office Notice of Privacy Practices.

Patient acknowledgment for above information:

Signature _____

Date_____

PRESCRIPTION DRUG MONITORING NOTIFICATION

By signing this form, you confirm that you have been notified that if you receive a prescription for a controlled substance (narcotic drug) from our office and fill that prescription at a pharmacy in Colorado, certain identifying prescription information, including the name of the patient, will be entered into a secure database maintained by Colorado's prescription drug monitoring program. State law requires pharmacies to report information about controlled substance prescriptions filled to the prescription drug monitoring database.

This database is used to help prevent inappropriate uses of controlled substances- like fraud and diversion. The prescription drug monitoring program database contains only records related to controlled substances (narcotic drugs like painkillers, muscle relaxants and steroids). It does not contain records about other prescription drugs like antibiotics, antidepressants or any other category of prescription medications.

Only authorized individuals, like healthcare personnel that prescribe controlled substances and law enforcement under very limited circumstances, can access the database and only for tightly defined uses. As long as you are using controlled drugs appropriately, there shouldn't be reason for concern. If you do not want your information in the database, please ask your dentist to prescribe non-narcotic drug for you.

More information about Colorado's prescription drug monitoring program, including copies of individual prescription drug records stored in the database, can be obtained from the Colorado state Department of Regulatory Agencies by calling 303-849-5957 or by visiting http://www.dora.state.co.us/pharmacy/pdmp/consumers.htm

I have read and understand this notification.

_____ _____

Date (Signature of patient/guardian)

If this notification is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Oral Surgery Center

I.V. Sedation Patients

I.V. sedation is **NOT** complete sleep. It is a medication given through an IV to relax you. Some of the reactions you might encounter are:

- Feeling relaxed
- Breathing will slow down
- Blood pressure will drop a little
- Feeling emotional (laughing or crying)

During your full procedure, you will be attached to a heart/breathing monitor and you will be monitored by your doctor and nurses.

You may not remember your surgery and you will be able to respond to your doctor through verbal stimulation.

If you desire complete sleep (General Anesthesia), please ask your doctor so you can be referred to a hospital.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____