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Diplomates of the American Board of Oral and Maxillofacial Surgery

We welcome you to our office. Please fill out this required information. Thank you.

Patient Name (First, MI, Last) ______________________________ SSN# ______________

Home Address ______________________ City ______________ State ______ Zip ______

Home Phone# ______________ Work Phone# ______________ Cell Phone# ______________

Birth Date ____________ DL# ________________ Age ___ Sex ___ Marital Status ________

Occupation ______________________ Work Address ______________________

School ______________________ City ______________________

Name of General Dentist ______________________ Phone Number ______________

Name of Family Physician ______________________ Phone Number ______________

Who is Financially Responsible? ______________ Whom should we thank for this referral? ______________

FILL IN FOR SPOUSE

Spouse's Name (First, MI, Last) ______________________________ SSN# ______________

Address ______________ City/State/Zip ______________ DL# ______________

Spouse's Employer ______________ Work Phone ______________ Cell Phone ______________

Work Address ______________________ City/State/Zip ______________________

FILL IN PARENTS INFORMATION IF APPLICABLE

Father's Name (First, MI, Last) ______________________________ SSN# ______________

Address ______________ City/State/Zip ______________ DL# ______________

Father's Employer ______________ Work Phone ______________ Cell Phone ______________

Work Address ______________________ City/State/Zip ______________________

Mother's Name (First, MI, Last) ______________________________ SSN# ______________

Address ______________ City/State/Zip ______________ DL# ______________

Mother's Employer ______________ Work Phone ______________ Cell Phone ______________

Work Address ______________________ City/State/Zip ______________________

1443 Cedarwood Ln. | Pleasanton, CA 94566 | **925-462-1533**
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OUR PAYMENT POLICY

I authorize any insurance benefit payment due to me, to be made directly to Northern California Facial and Oral Surgery. A service charge of 1.5% per month (18% annually) will be automatically added to all delinquent accounts past 60 days. A twenty-five dollar ($25) accounting fee will be charged on all returned checks. Payment is due as services are rendered.

Name of Person responsible for this account ______________________________

My payment will be made by ☐ Cash ☐ Check ☐ Credit Card (Visa or MasterCard)

Do you have Dental Insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________ Relationship ______________

Subscriber's Birthdate ______________________ Subscriber's Social Security # ______________

Subscriber's Employer ______________________ Employer Address ______________

Phone Number (________) ______________________

Name of Insurance Co. ______________________ Group Number ______________

Secondary Insurance Carrier ______________________ Relationship ______________

Subscriber's Birthdate ______________________ Subscriber's Social Security # ______________

Subscriber's Employer ______________________ Employer Address ______________

Phone Number (________) ______________________

Name of Insurance Co. ______________________ Group Number ______________

HOSPITAL (MEDICAL) INSURANCE INFORMATION

Subscriber's Name ______________________________ Relationship ______________

Subscriber's Birthdate ______________________ Subscriber's Social Security # ______________

Subscriber's Employer ______________________ Employer Address ______________

Phone Number (________) ______________________

Name of Insurance Co. ______________________ Group Number ______________

______________________ ______________________________

Date Signature

HEALTH QUESTIONNAIRE

Dental care is part of your overall health. In order that we may provide you with the best possible care, please complete this form as thoroughly as possible.

Age ______________ Weight ______________

1. Date of complete examination with your physician? ______________
2. Did he/she find any unusual problems? .... ☐ YES ☐ NO
   What? ______________
3. Have you had any other past serious illness or conditions requiring a physician's care that may have a bearing on your case? .... ☐ YES ☐ NO
   What? ______________
4. Have you been a hospital patient? .... ☐ YES ☐ NO
   If so, for what and date ______________
5. Are you taking any medication under doctor's orders now? .... ☐ YES ☐ NO
   If so, name of each drug ______________
6. Are you allergic to ☐ Penicillin ☐ Codeine ☐ Demerol ☐ Valium ☐ Erythromycin ☐ Aspirin ☐ Tylenol ☐ Latex gloves or any other drugs, non-prescription drugs, materials, or foods? .... ☐ YES ☐ NO
   ____
7. Have you taken any of these drugs in the past 6 months? ☐ Aspirin ☐ Coumadin ☐ Anticoagulants (blood thinners) ☐ Steroids ☐ Cortisones ☐ Heart Medicine? .... ☐ YES ☐ NO
   ____
8. Have you used any Recreational/Street Drugs in the past 6 months? .... ☐ YES ☐ NO
   Medications used in oral & maxillofacial surgery may interact with both prescription and recreational/street drugs used presently and in the past. These interactions may produce harmful results including death. This information will be kept strictly confidential.
9. Have you had a recent cough or cold? .... ☐ YES ☐ NO
10. Do you smoke? .... ☐ YES ☐ NO
    If so, how many packs per day? ______________ How many years? ______________
11. Please CHECK any of the conditions you may have had or still have:

☐ Aids/Arc
☐ Alcoholism
☐ Anemia
☐ Angina Pectoris
☐ Ankle Swelling
☐ Asthma
☐ Arthritis
☐ Bleeding Disease
☐ Blood Transfusions
☐ Bruise Easily
☐ Bruxism (Grinding Teeth)
☐ Cancer
☐ Cancer Radiation
☐ Chest Pain
☐ Chemotherapy
☐ Chronic Cough
☐ Contact Lenses
☐ Cortisone Treatment
☐ Diabetes
☐ Dizziness
☐ Drug Addiction
☐ Emphysema
☐ Excessive Bleeding
☐ Epilepsy (Seizures)
☐ Fainting/Dizziness
☐ Glaucoma
☐ Hepatitis (A), (B) Or (C)
☐ Heart Attack
☐ Heart Disease
☐ Heart Failure
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Heart Valve Replacement
☐ Herpes
☐ High Blood Pressure
☐ HIV Positive
☐ Irregular Heart Beat
☐ Kidney Disease
☐ Kidney Dialysis
☐ Leukemia
☐ Nervousness
☐ Prolapsed Mitral Valve
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Sinus Trouble
☐ Shortness Of Breath
☐ Sickle Cell Disease
☐ Psychiatric Treatment
☐ TB (Tuberculosis)
☐ Thyroid Disease
☐ Ulcers
☐ X-Ray Treatment

12. List any other conditions not mentioned above ______________
13. Have you ever received a local or general anesthetic? .... ☐ YES ☐ NO
    Did you experience any unfavorable reaction or result? .... ☐ YES ☐ NO
    What? ______________

14. Do you have any TMJ (Temporomandibular Joint), lower joint problems, locking, popping, clicking or pain? ☐ YES ☐ NO
    What kind of problems? ______
15. Have you ever had any artificial implants such as heart valves, joints (hip, knee, elbow), or organ transplants (heart, liver, kidney, etc.) ☐ YES ☐ NO
    If so, please explain ______
16. Have you been treated for any cancers or tumors? ☐ YES ☐ NO
    What kind? ______
17. Are you or have you taken diet pills (Fen-Phen, Redux, etc.) ☐ YES ☐ NO
    ______
18. Other Comments ______

FOR WOMEN ONLY

19. Are you pregnant, possibly pregnant, or trying to get pregnant? ☐ YES ☐ NO
    ______
20. Do you take birth control pills? ☐ YES ☐ NO
    ______

If you take birth control pills and are given Penicillin or a similar antibiotic during the course of your treatment, please be advised that antibiotics and other medications can make your birth control pill less effective and result in an unwanted pregnancy.

I verify that the information given on this form is accurate and complete to the best of my knowledge. I authorize this practice to obtain from, release to any medical/dental provider, insurance company, or any other agency, any information needed in regards to my health care.

______ Patients Signature (Parent or legal guardian if patient is under 18) Date

______ Doctors Signature