ORAL & FACIAL
SURGEONS OF ILLINOIS
ORAL, MAXILLOFACIAL & IMPLANT SURGERY

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Welcome to Our Practice

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name: _____ M.I.: _____ Last Name: _____

Nickname: _____ Sex: ☐ M ☐ F DOB: _____ Age: _____ Soc. Sec. #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____ Ext. _____ Cell Phone: _____

Dentist: _____ Physician: _____

Emergency Contact #: _____ Email: _____

COMPLETE ONLY IF PATIENT IS A DEPENDENT

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name: _____ S.S. #: _____ Home Phone: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Employer Phone: _____

INSURANCE INFORMATION

Student: ☐ Full-Time ☐ Part-Time ☐ N/A School Name/Address: _____

☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Do you belong to a PPO or HMO? ☐ Yes ☐ No

Primary Dental Insurance

Employer: _____ Bus. Address: _____ Bus. Phone: _____

Ins. Co. Name: _____ Address: _____

Phone: _____ Group #: _____ Group Name: _____

Insured Party: _____ Relation: _____ Sex: ☐ M ☐ F DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ S.S. #: _____ ID #: _____

Secondary Dental Insurance

Employer: _____ Bus. Address: _____ Bus. Phone: _____

Ins. Co. Name: _____ Address: _____

Phone: _____ Group #: _____ Group Name: _____

Insured Party: _____ Relation: _____ Sex: ☐ M ☐ F DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ S.S. #: _____ ID #: _____

Primary Medical Insurance

Employer: _____ Bus. Address: _____ Bus. Phone: _____

Ins. Co. Name: _____ Address: _____

Phone: _____ Group #: _____ Group Name: _____

Insured Party: _____ Relation: _____ Sex: ☐ M ☐ F DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ S.S. #: _____ ID #: _____

Secondary Medical Insurance

Employer: _____ Bus. Address: _____ Bus. Phone: _____

Ins. Co. Name: _____ Address: _____

Phone: _____ Group #: _____ Group Name: _____

Insured Party: _____ Relation: _____ Sex: ☐ M ☐ F DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ S.S. #: _____ ID #: _____

Health History Questionnaire

Patient Name: _____ Sex: ☐ M ☐ F DOB: _____

Weight: _____ Age: _____ Physician (Name): _____

Dentist (Name): _____ Referred By: _____

Orthodontist (Name): _____

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication 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. The information asked in this questionnaire is strictly confidential.

- Are you in good health? ..... ☐ Yes ☐ No
- Have there been any changes in your general health in the past year? ..... ☐ Yes ☐ No
- Are you under the care of a physician? ..... ☐ Yes ☐ No

If so, for what condition? _____ **Date of Last Exam:** _____

MEDICATIONS: Are you taking any of the following medications? (Check all that apply.)

- ☐ Antibiotics
- ☐ Anticoagulants (Blood Thinners)
- ☐ Blood Pressure Medication
- ☐ Cortisone
- ☐ Prednisone
- ☐ Steroids
- ☐ Tranquilizers
- ☐ Nerve Pills
- ☐ Aspirin
- ☐ Insulin/Diabetic Pills
- ☐ Nitroglycerin
- ☐ Heart Medications
- ☐ Inderal® (Beta-blockers)
- ☐ Digoxin
- ☐ Calcium Channel Blockers
- ☐ Ulcer Medication
- ☐ Seizure Medication
- ☐ Thyroid Medication
- ☐ Antihistamines/Decongestants
- ☐ Any "Street Drug"

List the names of all medications you are currently taking: _____

_____

ALLERGIES: Are you allergic to or have you had a bad reaction to any of the following? (Check all that apply.)

- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Local Anesthetics (Novocain®, Xylocaine®)
- ☐ Codeine
- ☐ Aspirin or Ibuprofen
- ☐ Barbiturates
- ☐ Sedatives
- ☐ Latex Products
- ☐ General Anesthesia
- ☐ Soy/Eggs
- ☐ Bisulfates
- ☐ Other: _____

_____

- Do you have or have you ever had any of the following? (Check all that apply.)

  - ☐ Bleeding Problems
  - ☐ Bleeding Disorder
  - ☐ Anemia
  - ☐ Blood Clotting Disorder
  - ☐ Blood Transfusion
  - ☐ Abnormal Bleeding
  - ☐ Bruise Easily
  - ☐ Congenital Heart Defect
  - ☐ Heart Murmur
  - ☐ Mitral Valve Prolapse
  - ☐ Rheumatic Fever/Heart Disease
  - ☐ Heart Disease
  - ☐ Heart Attack
  - ☐ Coronary Artery Disease
  - ☐ Angina Pectoris
  - ☐ Congestive Heart Failure
  - ☐ Previous Heart Surgery, Stroke, Palpitations, Pacemaker, Other: _____
  - ☐ High Blood Pressure
  - ☐ Low Blood Pressure
  - ☐ Lung Disease/Breathing Problems
  - ☐ Asthma, Emphysema, Tuberculosis, Bronchitis, Chronic Lung Disease, Pneumonia, Severe Coughing
    Other: _____
  - ☐ Diabetes, Kidney Disease, or Liver Disease (Hepatitis, Jaundice)
    If so, explain: _____
  - ☐ Chest Pain, Shortness of Breath
  - ☐ Swelling of the Ankles
  - ☐ Thyroid Problems, Stomach Ulcers
  - ☐ Seizures or Epilepsy
  - ☐ Nervous Breakdown/Psychiatric Treatment
  - ☐ Glaucoma
  - ☐ X-ray Treatments for Tumor or Chemotherapy
  - ☐ Smoke Tobacco
    If so, how much? _____
  - ☐ Drink Alcohol
    If so, how much? _____

- Does your family have any tendency toward complications with anesthesia? ..... ☐ Yes ☐ No
- Have you had any previous operation or surgery? ..... ☐ Yes ☐ No

If so, please list all the operations and types of anesthesia: _____

_____

- Have you been hospitalized in the past 5 years? ..... ☐ Yes ☐ No

If so, for what condition? _____

- Do you have implants placed anywhere in your body? (heart valve, hip, knee, other joint) ..... ☐ Yes ☐ No
- Are you taking or have you taken bisphosphonates (Fosamax®, Actonel®, Zometa®, Aredia®, Didronel®, Boniva®, Skelid®) for osteoporosis, chemotherapy for multiple myeloma, or other metastatic bone cancer, etc.? ..... ☐ Yes ☐ No

When? _____ **Oncologist Name:** _____

Health History Questionnaire (Cont.)

- Are you wearing contact lenses? ☐ Yes ☐ No
- Have you been exposed to any communicable diseases or viruses, or do you have any impairment of your immune system? ☐ Yes ☐ No
- Do you abuse or have you abused alcohol or habit-forming drugs? ☐ Yes ☐ No
- Do you have or have you ever had jaw joint problems? (Check all that apply.)
  - ☐ Clicking or Popping of Jaw ☐ Jaw Clenching ☐ Previous Treatment for Jaw Problem
  - ☐ Pain Near Ear ☐ Difficulty Opening Mouth If so, explain: _____
- Do you have any other medical problems or condition not listed above? ☐ Yes ☐ No
  If so, explain: _____
- To your knowledge, is there any reason why surgery or anesthesia should not be performed on you? ☐ Yes ☐ No
  If so, explain: _____
- Have you had anything to eat or drink in the last 6 hours? ☐ Yes ☐ No
- Are you on any weight loss or other special diets? ☐ Yes ☐ No

WOMEN ONLY:

- Are you pregnant, do you have reason to suspect you may be pregnant, or are you planning a pregnancy?... ☐ Yes ☐ No
  Estimated delivery date: _____
- Are you nursing? ☐ Yes ☐ No
- Are you taking birth control pills? ☐ Yes ☐ No

Women's Note: It has been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of birth control pills. I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed.

FEES & PAYMENTS

We make every effort to keep down the cost of your oral surgical 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 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 at the top of the 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. We will gladly bill your insurance company as a courtesy, but you are responsible for the entire bill regardless of deductibles or copays.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of the insurance benefits otherwise payable to me directly to the dentist named.

Date: _____ **Signature:** _____

Notice: Any unpaid balance of your account that is over 60 days due will be subject to a service charge. The service charge will be an amount determined by applying a periodic rate of 1.5% per month (18% APR) with a minimum of $1.00 to any part of your account balance that is unpaid 60 days after the first date of service. The guarantor will be responsible for any extra fees and liable for all charges and collection fees if needed to collect this bill. Responsibility of this account remains that of the guarantor, regardless of insurance coverage.

Date: _____ **Signature:** _____

Remarks: _____

_____

I certify that I have read and understand the above. I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I will not hold my surgeon or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Person Completing Health History: _____

(Parent's or legal guardian's signature required if patient is under 18 years of age)

Medical Update: I have read my health history dated _____/_____/_____ and confirm that it adequately states past and present conditions.

Date: _____ **Exceptions or Changes:** _____

Patient Signature: _____ **Dr.'s Initials:** _____

Date: _____ **Exceptions or Changes:** _____

Patient Signature: _____ **Dr.'s Initials:** _____