

**PATIENT INFORMATION**

**San Diego Center for Oral and Facial Surgery**

(Mr., Mrs., Ms., Dr.) First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Sex: ( ) Male ( ) Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Street: \_\_\_\_\_ Apt./Suite# \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Tel. ( ) \_\_\_\_\_ Bus. Tel. ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_  
 Driver's License# \_\_\_\_\_ Driver's Lic. State: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Primary Dentist: \_\_\_\_\_ Referred By: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**If someone else is responsible for your account, please complete:**  
 Who will be responsible (guarantor) for your account? Relation: ( ) Spouse ( ) Mother ( ) Father ( ) Other \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Home Tel: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Bus. Tel: ( ) \_\_\_\_\_ Social Sec.# \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_ Driver's Lic. State: \_\_\_\_\_

In case of **EMERGENCY**, contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Home Tel. ( ) \_\_\_\_\_ Work Tel.( ) \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_

**College Students Age 19 and Older:** School Name: \_\_\_\_\_ Full Time / Part Time

**INSURANCE COMPANY INFORMATION (to assist in utilizing your insurance benefits, please be thorough as possible):**

	The information below is required if you do not have your insurance card(s) with you.	The information below is required if the primary subscriber is different than the guarantor above or if there is a secondary subscriber.
<b>Primary Dental Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____ START DATE OF PRIMARY INS.: _____	Primary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____
<b>Secondary Dental Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____ START DATE OF SECONDARY INS.: _____	Secondary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____
<b>Medical Insurance</b>	Ins. Co. Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: ( ) _____ Group# _____ Employer Name: _____	Primary Subscriber: _____ Relationship to Patient: ( ) Spouse ( ) Father ( ) Mother ( ) Stepfather ( ) Stepmother ( ) Other _____ Date of Birth: _____ Phone: ( ) _____ Social Security# _____ or Subscriber ID# _____

**FEES AND PAYMENTS:** We make every effort to help you manage the costs of your oral surgical care. You can assist 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. If you have any dental and/or medical insurance, we will be able to complete the proper insurance forms as a courtesy to you. 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, coinsurance, co-pays, estimated patient portion, or any other balance not paid for by your insurance carrier upon delivery of service.

This signature on file is my authorization for the release of any information necessary to process my claim. I hereby authorize payment directly to the doctor named on the insurance benefits otherwise payable to me. I agree to pay all reasonable costs and attorney's fees, if I do not pay any of the bills incurred.

**Signature of Patient or Legal Guardian Representing Patient (Guarantor):** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate YES or NO if you have or had any of the following:

YES NO	YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Recent illness (within 1 year)	<input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat/palpitations	<input type="checkbox"/> <input type="checkbox"/> Thyroid disease
<input type="checkbox"/> <input type="checkbox"/> Cough, cold or flu (recent)	<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Seizures or epilepsy
<input type="checkbox"/> <input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> <input type="checkbox"/> Loud Snoring	<input type="checkbox"/> <input type="checkbox"/> Scarlet fever	<input type="checkbox"/> <input type="checkbox"/> Liver disease
<input type="checkbox"/> <input type="checkbox"/> Difficulty opening mouth / TMJ	<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Cirrhosis of the liver
<input type="checkbox"/> <input type="checkbox"/> Lung disease	<input type="checkbox"/> <input type="checkbox"/> Blood vessel grafts	<input type="checkbox"/> <input type="checkbox"/> Jaundice
<input type="checkbox"/> <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> <input type="checkbox"/> Heart surgery	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> <input type="checkbox"/> Bronchitis	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Artificial joints	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> <input type="checkbox"/> Cortisone or steroid use	<input type="checkbox"/> <input type="checkbox"/> HIV+ / AIDS
<input type="checkbox"/> <input type="checkbox"/> Heart failure	<input type="checkbox"/> <input type="checkbox"/> Extensive bleeding	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Chest pain	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Heart attack	<input type="checkbox"/> <input type="checkbox"/> Treatment for tumor or cancer/radiation	

Antibiotic and pain medications can alter the effectiveness of birth control pills. Use another method of birth control for the remainder of the menstrual cycle while taking antibiotics or pain medications. (If this applies to you, please initial: \_\_\_\_\_)

YES NO
<input type="checkbox"/> <input type="checkbox"/> Are you in good health?
<input type="checkbox"/> <input type="checkbox"/> Are you having pain or discomfort at this time?
<input type="checkbox"/> <input type="checkbox"/> Have you had a bad experience with previous dental or surgical treatment?
<input type="checkbox"/> <input type="checkbox"/> Have you been under the care of a physician or hospitalized during the past two years? If yes for what? _____
<input type="checkbox"/> <input type="checkbox"/> Have you ever gone to sleep for an operation? If yes for what? _____
<input type="checkbox"/> <input type="checkbox"/> Have you had any complications from anesthesia or previous surgery? If yes please describe: _____
<input type="checkbox"/> <input type="checkbox"/> Have any family members had a serious reaction to a general anesthetic?
<input type="checkbox"/> <input type="checkbox"/> Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills): _____
<input type="checkbox"/> <input type="checkbox"/> Have you ever taken weight loss medication (e.g. FenPhen/Metabolife) or any herbal or homeopathic supplements (e.g. vitamin E)? _____
<input type="checkbox"/> <input type="checkbox"/> Have you or do you currently take any medications for osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, Reclast, Aredia, or Zometa? _____
<input type="checkbox"/> <input type="checkbox"/> Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs: _____
<input type="checkbox"/> <input type="checkbox"/> Do you smoke or chew tobacco? If yes, how long? _____ If you smoke, how many packs a day? _____
<input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If yes, how many months? _____
<input type="checkbox"/> <input type="checkbox"/> Do you wear dentures or partials?
<input type="checkbox"/> <input type="checkbox"/> Do you wear contact lenses?

Please indicate if you have allergies of any type, including allergies to soy or soy products, milk or milk products, or latex:

YES NO	YES NO
<input type="checkbox"/> <input type="checkbox"/> Penicillin / ampicillin / amoxicillin	<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Novocain - local anesthetics - epinephrine	<input type="checkbox"/> <input type="checkbox"/> Barbiturates
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Other drugs/medications/foods/materials: _____

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health status, or if my medications change, I will inform the doctor accordingly.

Patient's or legal guardian's signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor, please indicate relationship to patient: \_\_\_\_\_

For Office Use Only

Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____
Date: _____	BP: _____	Pulse: _____	Resp: _____	Weight: _____	Ht: _____	ASA: _____	Reviewed by: _____