PATIENT INFORMATION **West Coast Oral 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: _____
E-Mail Address:_____
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: ( ) _____

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.**
Primary Dental Insurance	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# _____
Secondary Dental Insurance	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# _____
Medical Insurance	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:**_____

Health Care Questionnaire: CONFIDENTIAL **West Coast Oral Surgery**

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	
O	O	Recent illness (within 1 year)	O	O	Irregular heartbeat/palpitations	O	O	Thyroid disease
O	O	Cough, cold or flu (recent)	O	O	Heart murmur	O	O	Seizures or epilepsy
O	O	Nasal obstruction	O	O	Rheumatic fever	O	O	Psychiatric treatment
O	O	Loud Snoring	O	O	Scarlet fever	O	O	Liver disease
O	O	Difficulty opening mouth / TMJ	O	O	High blood pressure	O	O	Cirrhosis of the liver
O	O	Lung disease	O	O	Blood vessel grafts	O	O	Jaundice
O	O	Shortness of breath	O	O	Heart surgery	O	O	Hepatitis
O	O	Asthma	O	O	Stroke	O	O	Stomach ulcer
O	O	Bronchitis	O	O	Arthritis	O	O	Diabetes
O	O	Emphysema	O	O	Artificial joints	O	O	Kidney Disease
O	O	Tuberculosis (TB)	O	O	Cortisone or steroid use	O	O	HIV+ / AIDS
O	O	Heart failure	O	O	Extensive bleeding	O	O	Osteoporosis
O	O	Chest pain	O	O	Anemia	O	O	Other_____
O	O	Heart attack	O	O	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	
O	O	Are you in good health?
O	O	Are you having pain or discomfort at this time?
O	O	Have you had a bad experience with previous dental or surgical treatment?
O	O	Have you been under the care of a physician or hospitalized during the past two years? If yes for what?_____
O	O	Have you ever gone to sleep for an operation? If yes for what?_____
O	O	Have you had any complications from anesthesia or previous surgery? If yes please describe: _____
O	O	Have any family members had a serious reaction to a general anesthetic?
O	O	Are you taking any medications? Please list (include over the counter medications, products with aspirin or ibuprofen, vitamins, birth control pills):_____ _____
O	O	Have you ever taken weight loss medication or any herbal or homeopathic supplements (e.g. vitamin E or fish oil)? _____
O	O	Have you or do you currently take any medications for osteoporosis or bone cancer such as Fosamax, Boniva, Actonel, Reclast, Aredia, Zometa, Didronel or Skelid? _____
O	O	Have you used recreational drugs during the last year? Please list as they can be dangerous in conjunction with anesthetic drugs: _____
O	O	Do you smoke or chew tobacco? If yes, how long?_____ If you smoke, how many packs a day?_____
O	O	Are you pregnant? If yes, how many months?_____
O	O	Do you wear dentures or partials?
O	O	Do you wear contact lenses?
O	O	Do you have trouble swallowing pills?

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	
O	O	Penicillin / ampicillin / amoxicillin	O	O	Aspirin
O	O	Novocain - local anesthetics - epinephrine	O	O	Barbiturates
O	O	Codeine	O	O	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:_____