Beverly Hills Oral & Maxillofacial Surgery Institute

PATIENT INFORMATION

LAST NAME ______ FIRST NAME ______ MI ______ *MALE* ☐ *FEMALE* ☐

ADDRESS ______ # ______ CITY ______ ST ______ ZIP ______

DATE OF BIRTH ______ *SINGLE* ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ EMAIL ______

MINORS: MOTHER'S NAME ______ HER DOB ______ FATHER'S NAME ______ HIS DOB ______

PATIENT'S SS# ______ DL# ______ ST ______ **HOME** ( ) ______

INSURANCE SUBSCRIBER ______ SS# OR INS. ID# ______ **CELL** ( ) ______

EMPLOYED BY ______ POSITION ______ **WORK** ( ) ______

WORK ADDRESS ______ CITY ______ ST ______ ZIP ______

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ______ **EMERGENCY** ( ) ______

NAME OF ANOTHER RELATIVE NOT LIVING WITH YOU ______ **RELATIVE** ( ) ______

SPOUSE'S NAME ______ **SPOUSE'S CELL** ( ) ______

SPOUSE'S EMPLOYER ______ POSITION ______ **SPOUSE'S WORK** ( ) ______

SPOUSE'S WORK ADDRESS ______ CITY ______ ST ______ ZIP ______

SPOUSE'S SS# ______ DL# ______ ST ______ SPOUSE'S DOB ______

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE? MY DENTIST ☐ INTERNET ☐ FRIEND ☐ INSURANCE ☐ OTHER ______

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______ ______ **PHONE** ( ) ______

NAME OF YOUR DENTIST OR DENTAL GROUP: ______ ______ **DENTIST'S** ( ) ______

DENTAL INFORMATION

	YES	*NO*
ARE YOU HAVING PAIN OR DISCOMFORT?	☐	☐
Have you ever had local anesthetic (Novocaine etc.)?	☐	☐
Have you ever had an unfavorable reaction to local anesthetic?	☐	☐
Have you ever had a serious problem with dental treatment?	☐	☐
DO YOU GRIND OR CLENCH YOUR TEETH?	☐	☐
ARE YOUR WISDOM TEETH CAUSING PROBLEMS?	☐	☐
DO YOUR GUMS EVER BLEED?	☐	☐
Does your oral surgery treatment make you nervous?	☐	☐
DO YOUR JAW JOINTS HURT, CLICK OR POP?	☐	☐
DOES YOUR CURRENT PROBLEM REQUIRE PAIN MEDS?	☐	☐

IF YES TO ANY OF ABOVE PLEASE EXPLAIN ______

MEDICAL INFORMATION

	YES	*NO*	*PLEASE EXPLAIN OR LIST IF APPLICABLE*
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW?	☐	☐	______
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	☐	☐	______
ARE YOU TAKING ANY MEDICATIONS OR DRUGS NOW?	☐	☐	______
HAVE YOU TAKEN ANY MEDICATION OR DRUG IN THE PAST 5 YEARS?	☐	☐	______
ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS OR LATEX?	☐	☐	______
SENSITIVE OR ALLERGIC TO ANY FOODS OR HOUSEHOLD MATERIALS?	☐	☐	______

PHYSICIAN'S NAME ______ **PHYSICIAN'S** ( ) ______

PHYSICIAN'S ADDRESS ______

FOR WOMEN ONLY

	YES	*NO*	*MAYBE*	*MONTH*
ARE YOU PREGNANT OR POSSIBILITY OF IT?	☐	☐	☐	______
ARE YOU NURSING / BREAST-FEEDING?	☐	☐		
ARE YOU TAKING BIRTH-CONTROL PILLS?	☐	☐		

WARNING: THE EFFECTIVENESS OF BIRTH-CONTROL PILLS IS REDUCED BY ANTIBIOTICS. IF YOU ARE PRESCRIBED ANTIBIOTICS, USE OTHER FORMS OF BIRTH-CONTROL DURING THIS CYCLE AND NEXT TO AVOID PREGNANCY.

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE SUPPLY THE DATE OF OCCURRENCE.

	DATE	*YES*	*NO*		*DATE*	*YES*	*NO*		*DATE*	*YES*	*NO*
ORGAN TRANSPLANT		☐	☐	ARTIFICIAL JOINTS (Hip, knee, etc.)		☐	☐	EPILEPSY OR SEIZURES		☐	☐
ANY HEART CONDITION		☐	☐	KIDNEY TROUBLE		☐	☐	FAINTING OR DIZZY SPELLS		☐	☐
HEART ATTACK		☐	☐	ULCERS		☐	☐	ALLERGIES /HIVES/ HAY FEVER		☐	☐
HEART MURMUR		☐	☐	DIABETES TYPE 1____ TYPE 2____		☐	☐	LATEX ALLERGY		☐	☐
MITRAL VALVE PROLAPSE		☐	☐	THYROID PROBLEMS		☐	☐	HEPATITIS A, B, OTHER FORMS		☐	☐
ARTIFICIAL HEART VALVE		☐	☐	GLAUCOMA		☐	☐	LIVER DISEASE		☐	☐
ANGINA PECTORIS (CHEST PAIN)		☐	☐	CANCER		☐	☐	YELLOW JAUNDICE		☐	☐
CONGENITAL HEART DISEASE		☐	☐	RADIATION THERAPY		☐	☐	BRUISE EASILY/EXCESSIVE BLEEDING		☐	☐
IRREGULAR HEART BEAT		☐	☐	CHEMOTHERAPY		☐	☐	HEMOPHILIA/ SICKLE CELL DISEASE		☐	☐
PACEMAKER		☐	☐	TUMORS OR GROWTHS		☐	☐	ANEMIA		☐	☐
HEART SURGERY		☐	☐	ASTHMA		☐	☐	BLOOD TRANSFUSION		☐	☐
ARTERIOSCLEROSIS		☐	☐	EMPHYSEMA		☐	☐	HIV POSITIVE or AIDS		☐	☐
SHORTNESS OF BREATH		☐	☐	TUBERCULOSIS OR COUGH		☐	☐	MENTAL DISORDER		☐	☐
SCARLET FEVER		☐	☐	RESPIRATORY DISEASE		☐	☐	PSYCHIATRIC TREATMENT		☐	☐
RHEUMATIC FEVER		☐	☐	SINUS PROBLEMS		☐	☐	GENITAL HERPES		☐	☐
HIGH BLOOD PRESSURE		☐	☐	ARTHRITIS		☐	☐	VENEREAL DISEASE		☐	☐
LOW BLOOD PRESSURE		☐	☐	RHEUMATISM		☐	☐	COLD SORES OR FEVER BLISTERS		☐	☐
STROKE		☐	☐	DEVELOPMENTAL DISABILITY		☐	☐	OSTEOPOROSIS		☐	☐
NERVOUSNESS OR DISORDER		☐	☐	CORTISONE MEDICATION		☐	☐	OSTEOPOROSIS MEDICATIONS		☐	☐
PSYCHIATRIC TREATMENT		☐	☐	CEREBRAL PALSY		☐	☐	DRUG ADDICTION OR USE		☐	☐

Other conditions not listed that you think we should know: ____________________

DO YOU EVER HAVE SHORTNESS OF BREATH OR CHEST PAIN WHEN YOU WALK UP STAIRS? ____________________

HAVE YOU USED BISPHOSPHONATE MEDICATIONS (*EXAMPLES*: FOSAMAX, BONIVA, AREDIA, ZOMETA, ACTONEL)? ____________________

Are you currently taking or have you ever taken the drug Phen-Phen, any herbal or holistic medicines?

CONSENT

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or medications, I shall inform the office staff immediately verbally and in writing.

I, the undersigned, hereby authorize this office to obtain pertinent medical information from my physician as it relates to my dental health. I also authorize this office to take any necessary x-ray images for the purpose of dental diagnosis by a doctor.

I authorize this office to obtain information on my behalf from my insurance company to determine eligibility and benefits for dental services. I also authorize this office to bill my insurance company and receive payment directly. However, I understand that insurance coverage is not guaranteed. If for any reason my insurance company does not cover or pay this office for any and all charges incurred, I, the patient, accept full responsibility and will pay my bill immediately.

INITIALS

____ I understand that I, the patient (parent / legal guardian), am fully responsible for all charges incurred in this office.

____ I understand that all records and x-rays are the legal property of this office and there is a fee for duplication.

____ I have read and agree to the OFFICE POLICIES (*v. Mar. 5, 2009*) received in the office or on the web site.

____ I have read and agree to the HIPAA PRIVACY RULES (*v. Mar. 5, 2009*) received in the office or on the web site.

____ I have received the NOTICE OF PRIVACY PRACTICES (*v. Feb. 19, 2008*) in the office or on the web site.

____ I have received the DENTAL MATERIALS FACT SHEET in the office or on the web site.

UPDATED

DR. _____ DATE _________
DR. _____ DATE _________
DR. _____ DATE _________
DR. _____ DATE _________

X ______________________________ DATE ______________

Signature (parent or guardian if patient is a minor)

REVIEWED BY DR. ______________________________ DATE ______________