Welcome To Our Practice

Date:_____

1.IP

Patient: (Mr., Mrs., Ms., Dr.) First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: ❑ Male ❑ Female Date of Birth _____ Age_____ Soc. Sec.#_____ Email (optional)_____

Street _____ City_____ State _____ Zip_____

Home Tel.# (_____) _____ Business Tel. # (_____) _____ Ext._____ Employer_____

Dentist_____ Medical Doctor_____ Referred By _____

Driver's Lic. #_____ Nearest relative not living with you_____ Tel. # (_____) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other_____
(If self, skip to next paragraph)

Name _____ Soc. Sec.#_____ Home Tel. (_____) _____

Street_____ City_____ State _____ Zip_____

Employer_____ Tel. (_____) _____

Spouse or other guarantor information (if different from above)

Name_____ Relation_____ Soc. Sec.#_____ Home Tel. (_____) _____

Street_____ City_____ State _____ Zip _____

Employer_____ Tel. (_____) _____

INSURANCE INFORMATION

1.I0

Patient: Student: Full Time ❑ Part Time ❑ Not ❑ School Name/Address_____

Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single ❑ _____

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

PRIMARY DENTAL INSURANCE COMPANY

❶ **Employer**_____

Bus. Address_____

Bus. Tel.# (_____) _____ Plan_____

1.I1 **Ins. Co. Name**_____

Address_____

_____ Tel.# (_____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street _____

City, State, Zip_____

Tel.# (_____) _____ S.S.#_____

I.D.#_____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel.# (_____) _____ Plan _____

Ins. Co. Name_____

Address_____

_____ Tel.# (_____) _____

Group #_____ **Group Name** _____

Insured Party_____ Relation_____

Sex: ❑ M ❑ F Date of Birth_____

Street_____

City, State, Zip_____

Tel.# (_____) _____ S.S.#_____

I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

❷ **Employer**_____

Bus. Address_____

Bus. Tel.# (_____) _____ Plan_____

1.I1 **Ins. Co. Name** _____

Address _____

_____ Tel.# (_____) _____

Group #_____ **Group Name** _____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth _____

Street_____

City, State, Zip _____

Tel.# (_____) _____ S.S.#_____

I.D.#_____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address_____

Bus. Tel.# (_____) _____ Plan _____

Ins. Co. Name_____

Address_____

_____ Tel.# (_____) _____

Group #_____ **Group Name**_____

Insured Party_____ Relation _____

Sex: ❑ M ❑ F Date of Birth_____

Street _____

City, State, Zip_____

Tel.# (_____) _____ S.S.#_____

I.D.#_____

Health History

Patient's Name _____ Date of Birth _____

I. Check appropriate answer (Leave blank if you do not understand the question)

1. ☐ Yes ☐ No Is your general health good?
   If No, explain _____
2. ☐ Yes ☐ No Has there been a change in your health within the last year?
   If Yes, explain _____
3. ☐ Yes ☐ No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If Yes, explain _____
4. ☐ Yes ☐ No Are you being treated by a physician now? If Yes, explain _____
   Date of last medical exam _____ Reason for exam _____
5. ☐ Yes ☐ No Have you had problems with prior dental treatment?
   If Yes, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. ☐ Yes ☐ No Are you in pain now? If Yes, explain _____

II. Have you experienced any of the following? (Check all that apply)

- ☐ Bleeding problems
- ☐ Blood in stools
- ☐ Blood in urine
- ☐ Blurred vision
- ☐ Bruise easily
- ☐ Chest pain (angina)
- ☐ Coughing up blood
- ☐ Diarrhea or constipation
- ☐ Difficulty swallowing
- ☐ Difficulty urinating
- ☐ Dizziness
- ☐ Dry mouth
- ☐ Excessive thirst
- ☐ Fainting spells
- ☐ Fever
- ☐ Frequent urination
- ☐ Frequent vomiting
- ☐ Headaches
- ☐ Jaundice
- ☐ Joint pain or stiffness
- ☐ Night sweats
- ☐ Persistent cough
- ☐ Recent significant weight loss/gain
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Swollen ankles

III. Have you had or do you have any of the following? (Check all that apply)

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial joint(s)
- ☐ Asthma
- ☐ Canker or cold sores
- ☐ Chemotherapy
- ☐ Cosmetic surgery
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Emphysema or other lung disease
- ☐ Eye disease
- ☐ Family history of diabetes
- ☐ Family history of heart disease
- ☐ Hardening of arteries
- ☐ Heart attack
- ☐ Heart defects
- ☐ Heart disease
- ☐ Heart murmurs
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ Hospitalization
- ☐ Kidney or bladder disease
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sexually transmitted disease
- ☐ Skin disease
- ☐ Stomach problems or ulcers
- ☐ Stroke
- ☐ Surgeries*
- ☐ Thyroid disease
- ☐ Transplants
- ☐ Tuberculosis
- ☐ Tumors or cancer

*Surgeries _____

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

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Demerol
- ☐ Erythromycin
- ☐ Food
- ☐ Latex
- ☐ Local anesthetic (Novocaine or Xylocaine)
- ☐ Metal
- ☐ Nitrous oxide
- ☐ Penicillin
- ☐ Percodan
- ☐ Tetracycline
- ☐ Valium
- ☐ Vicodin

Other Allergies _____

V. Are you taking or have you taken any of the following in the last three months? (Check all that apply)

- ☐ Alcohol
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Bisphosphonate (Fosamax—bone support medication)
- ☐ Over-the-counter medicines
- ☐ Recreational drugs
- ☐ Supplements
- ☐ Tobacco in any form
- ☐ Weight loss medications

Please list _____

Health History (continued)

VI. Women only

7. ☐ Yes ☐ No Are you or could you be pregnant? If Yes, when are you due? _____
8. ☐ Yes ☐ No Are you nursing?
9. ☐ Yes ☐ No Are you taking birth control pills?

VII. All patients

10. ☐ Yes ☐ No Do you have or have you had any other diseases or medical problems **NOT** listed on this form? If Yes, please explain: _____
11. ☐ Yes ☐ No Have you ever been premedicated for dental treatment? If Yes, why _____
12. ☐ Yes ☐ No Have you ever taken Fen-Phen? If Yes, when _____
13. ☐ Yes ☐ No Is there any issue or condition that you would like to discuss with the doctor in private?

The practice of oral surgery involves treating the whole person. If the doctor determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of treatment.

I authorize the oral surgeon to contact my physician.

Patient's Signature _____ Date _____

Patient's Name _____ Phone Number _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my oral surgeon of any change in my health and/or medication. Further, I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN) DATE SIGNATURE OF DOCTOR DATE

Medical updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient's signature	Changes to health history	Doctor's initials

ALAN ESLA, DDS, MD
ORAL AND MAXILLOFACIAL SURGERY
INFORMED CONSENT TO FEES AND CHARGES
EXTRACTIONS AND PATHOLOGY PATIENTS ONLY

Patient's Name_____

Date of Visit_____

In addition to the fees assessed for the procedure being performed by Alan Esla, DDS, MD, there are fees that are assessed to patient accounts in certain circumstances. Those fees and the reason for assessment are listed below.

- All appointments require a forty-eight (48) "business" hour notice for cancellation to avoid a cancellation fee of 10% of planned procedure being assessed to the account.

- All statements are to be handled within thirty (30) days from the date printed on the statement to avoid a late payment fee of $150 being assessed to the account.

**This fee is assessed after the following has occurred:

1. **all insurance payments have been received and processed**
2. **a statement has been sent to the patient for remaining balance**
3. **no activity on patient account for 30 consecutive days(the thirty (30) days begins on the date printed on the statement not on the day the patient receives the statement).**

- All returned checks are assessed an NSF fee of $25.

I have read this document, fully understand the information, and have had all my questions answered.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date