DOLMAN
ORAL SURGERY

Welcome To Our Practice

Patient: First Name _____ M.I. _____ Last Name _____

Street Address _____ Apt. # _____ City _____ State _____

Zip _____ Date of Birth _____ Social Security # _____ Sex: M F Age _____

Email _____ Are you a new patient? Y N Marital Status _____

Home Tel. # (_____) _____ Mobile # (_____) _____

Employer/School Name _____ Occupation _____

Employer/ School Address _____

Business Tel. # (_____) _____ ext _____

Employed: Full Time Part Time Retired Not Presently Employed

Emergency Contact: _____ Relation _____

Home Tel. # (_____) _____ Business Tel: # (_____) _____

Reason for today's visit: _____ **Referred By** _____

Dentist name: _____ Dentist's Tel. # _____

Physician Name: _____ Physician's Tel. # (_____) _____

Pharmacy Name: _____ Pharmacy Tel. # (_____) _____

Method of payment Cash Check Credit Card

Dental Insurance Company _____ Are you the member? Y N

Medical Insurance Company _____ Are you the member? Y N

Insurance Member's information: Name _____ Relation _____

Address _____ City _____ State _____ Zip _____

Soc. Sec # _____ Date of Birth _____ Home Tel. # (_____) _____

Employer _____ Tel. # (_____) _____

Please give your Dental & Medical Insurance cards, x-ray and Dentist referral to the front desk for claim filing.

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HEALTH HISTORY

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, please describe ..... Y N

_____

_____

6. Height _____ Weight _____
7. DO YOU HAVE OR HAVE YOU EVER HAD:
   - A. Rheumatic Fever or Rheumatic Heart Disease ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Heart Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease, (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal Problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. ARE YOU USING ANY OF THE FOLLOWING:
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners) ..... Y N
   - C. Aspirin or drugs such a Motrin, Aleve, Ibuprofen? ..... Y N
   - D. High Blood Pressure Medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drugs? ..... Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax, Actonel or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____
9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day?_____
11. Is there any past history of Alcoholic or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. FOR WOMEN ONLY
    - A. Are you Pregnant, or is there any chance you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ Name (print)

_____ Signature

_____ Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please Specify)

_____

_____

_____

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Financial Policy

We are pleased to welcome you to our office, new patients are always appreciated. In order to assist you in making payments for your treatment, we provide the following options. Please read these carefully and feel free to discuss them with our staff.

PAYMENT: We accept all major credit cards, care credit and cash.

IF YOU DO NOT HAVE INSURANCE: Payment is due in full at the time treatment is provided.

IF YOU ARE INSURED: We will submit the necessary forms to your insurance carrier. You are responsible (at the time of your appointment), for any deductible or co-payment NOT covered by the insurance carrier. Please be advised, we are unable to waive this fee and are required by law to collect co-payments. Once our office has received the insurance payment, you will be billed (with 15 day terms), for any remaining balance. If there is payment credit, you may apply the credit towards future dental work, or a check will be issued to you upon your request.

INSURANCE PATIENTS - PLEASE READ CAREFULLY: The amount of coverage by your insurance, may be based on a reduced fee schedule selected by your employer. It's possible that this may result in lower coverage than estimated.

IMPLANT CASES: A 50% deposit will be due upon scheduling for treatment.

EXTENDED CARE CASES: Special arrangements may be made for extended care cases. Please see our Office Administrator.

FINANCIAL CONSENT: I certify that I have read, understood, and agree to this financial policy as it applies to myself and includes any dependents.

We are highly sensitive to issues relating to economics. You will be provided with an estimate/anticipated reimbursement schedule. Please know that every effort will be made to optimize the reimbursement from your insurance company. Sometimes the insurance company pays us less than the anticipated amount. Therefore you may receive an invoice from us possibly months after your visit. We look forward to caring for you.

❑ I have read the above statement and it is acceptable to me.

Responsible Party's Signature:_____

Date: _____