PEARLAND ORAL & MAXILLOFACIAL SURGERY ASSOCIATES

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CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date of Birth: ____/____/_____ Age: _____

Address: _____ SSN: _____
Street

_____ Email: _____
City/State Zip

Phone: (Home) _____ (Work) _____ (Mobile) _____

Referred By: _____

EMERGENCY CONTACT:

Name: _____ Phone: (Mobile) _____ (Work) _____

IF MINOR, GUARANTOR OF ACCOUNT:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____
Street

_____ Work Phone: _____
City/State Zip

Driver's License: _____ State: _____

DENTAL INSURANCE:

Carrier: _____ Phone: _____

Claims Address: _____ City/State: _____ Zip: _____

Insured: _____ Date of Birth: ____/____/_____ SSN: _____

Group Number: _____ Employer: _____

ALL CHARGES ARE THE RESPONSIBILITY OF THE PATIENT OR GUARANTOR OF THE ACCOUNT AND ARE DUE AT THE TIME OF SERVICE. Filing of insurance claims is a courtesy. Estimates made by our office are not a guarantee of payment from your insurance company. It is important for you to be familiar with the terms, exclusions, and limitations of your insurance policies. We urge you to be fully aware of the provisions of your policy as benefits can vary greatly from company to company.

I agree to be responsible for all charges for services and materials not paid by my insurance plan, unless the treating doctor has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claims and/or appeals submitted by this office on my behalf. I also authorize the payment of benefits to the provider for services rendered. Please be advised in the event your account goes 60 days past due, it will be considered delinquent in our office. We reserve the right to charge a collection fee, and your account will be placed with a collection agency in which you will be responsible for the collection fees.

Signature: _____ Date: ____/____/_____

Health History Form

Patient's Name: _____ Date of Birth ____/____/_____

Gender: _____ Height: _____ Weight: _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your **current health**: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: _____

Have there been any **changes in your general health** in the past year? Yes No

If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam _____

Have you ever been **hospitalized** or had a **serious illness**? Yes No

If yes, why? _____

Have you ever had **surgery**? Yes No

If yes, when and what for? Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

Date of surgery: _____ Reason for surgery: _____

Have you ever had any **problems with anesthesia (**local anesthesia, general anesthesia, and/or IV sedation)? Yes No

If yes, please describe: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Cardiovascular disease, congenital heart disease, (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Gastrointestinal problems? Stomach ulcers, colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Cancer, radiation, or chemotherapy?	Yes	No	HIV/AIDS?	Yes	No
Describe: _____			Immunosuppression?	Yes	No

Do you have any other disease, condition or problem **not listed above** that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (**blood thinners**)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones, IV medications, or any other cancer drugs? If yes, list drugs used and time of use: _____	Yes	No

Please list all medications indicated above as well as any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

Pharmacy: _____ Phone: _____ Address: _____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Other drug or food allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought care or been hospitalized for:

Substance abuse?	Yes	No
Alcoholism?	Yes	No
Emotional disorders?	Yes	No

Do you use:

Alcohol?	Yes	No	How often? _____
Marijuana?	Yes	No	How often? _____
Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain? _____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend , or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose the FDA your protected health information relating to adverse events with respect to product defects, or post-marketing surveillance to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse or Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or it's agents, your protected health information necessary for your health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent and individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed ore required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures beside those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: 1/1/08
I, _____, hereby acknowledge that I can receive a copy of the practice's Notice of Privacy Practices. I have been given the opportunity to ask any question I may have regarding this Notice.

SIGNATURE: _____ **DATE:** _____

Please complete other side

PHARMACY NAME: _____ **PHONE:** _____

ADDRESS: _____
Street

_____
City/State **Zip**

DESIGNATED DRIVER: _____

PHONE: _____

PATIENT'S NAME: _____