Oyster Point Oral & Facial Surgery
Health History

Patient's Name _____
LAST FIRST MI

Age_____ Weight _____ Height_____ Sex: ❑ Male ❑ Female

Name of Physician _____

Name of Dentist _____

Referred By_____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING (Y) OR (N)
THIS OFFICE WILL HOLD THIS INFORMATION
IN THE UTMOST CONFIDENCE.

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 had any serious illnesses, operations or hospitalizations? If so, describe ..... Y N
   _____
   _____
6. Do you have or have you ever had (please circle)
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (heart trouble, heart attack, heart murmur, coronary heart disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker, mitral valve prolapse)? ..... 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, Psychiatric Treatment, Dizziness, Nervous Disorder or Breakdown? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, Easy Bruising? ..... 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. Frequent or Recurring Mouth Sores? ..... Y N
   - O. Implants placed anywhere in your body (heart valve, hip, knee, any total joint replacements)? ..... Y N
   - P. Radiation (x-ray) Treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain in ear, difficulty opening mouth, grinding or clenching teeth? ..... Y N
   - R. Sinus or nasal problems or snoring? ..... Y N
   - S. Migraines ..... Y N
   - T. Snoring, Sleep Apnea, Restless Leg Syndrome ..... Y N
   - U. Any disease, drugs or transplant operation that has depressed your immune system? ..... Y N
7. Are you using or taking any of the following:
   - A. Tagamet? ..... Y N
   - B. Thyroid Medications? ..... Y N
   - C. Antibiotics or Sulfa Drugs? ..... Y N
   - D. Anticoagulants (blood thinners)? ..... Y N
   - E. High Blood Pressure? ..... Y N
   - F. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - G. Tranquilizers (Valium, etc.)? ..... Y N
   - H. Insulin, Diabenese, or similar drug? ..... Y N
   - I. Digitalis, Inderal, Nitroglycerine, Calcium Channel Blockers, Procardia, or other Heart Medicine? ..... Y N
   - J. Aspirin or Ibuprofen (Motrin, Naprosyn, etc.) ..... Y N
   - K. Marijuana or other "Street Drugs" ..... Y N
   - L. Biophosphinates drugs, oral/I.V. ..... Y N
   - M. Antihistamines or Decongestants? ..... Y N
   - N. Are you taking any other regular medications, pills or drugs? ..... Y N
     If Yes, please list: _____
     _____
     _____
     _____
8. Are you allergic or have you reacted badly to:
   - A. Local Anesthetic (Novocaine, etc.)? ..... Y N
   - B. Penicillin, Amoxicillin, Cephalosporins, or other antibiotics? Y N
   - C. Barbiturates, Sedatives, etc.? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other painkillers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? ..... Y N
     If Yes, please list: _____
     _____
9. Do you smoke or chew tobacco? ..... Y N
   If Yes, how many per day: _____
10. Frequently use alcohol/recreational drugs ..... Y N
11. Do you have any other disease or problem not listed above that the doctor should know about? ..... Y N
12. If female, are you pregnant? ..... Y N

FOR FEMALE PATIENTS ONLY

A. If you are using contraceptives it is important that you understand that antibiotics and 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 medications is completed. Please consult with your physician for further guidance.

B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant.

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST IN PROVIDING THE BEST CARE POSSIBLE.

Patient, Parent/Guardian Signature _____ Date _____

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY ABOVE AND CONFIRM THAT IT ADEQUATELY REFLECTS MY MEDICAL CONDITION, PAST AND PRESENT.

Patient, Parent/Guardian Signature _____ Date _____

Oyster Point Oral & Facial Surgery

Patient Registration Form

PATIENT INFORMATION:

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apt#:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

Social Security #: _____ **Home Phone: ( )** _____ **Work Phone: ( )** _____

Sex: Male☐ Female☐ Marital Status: S☐ M☐ D☐ W☐ Date of Birth: _____ **Age:** _____

Occupation: _____ **If Student, School:** _____

If Employed, Employer: _____ **Address:** _____

Spouse's Name: _____ **SS#:** _____ **Employer:** _____

My dentist is: _____ **I was referred to this practice by:** _____

RESPONSIBLE PARTY (if different than patient):

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apt#:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

SS#: _____ **Date of Birth:** _____ **Relationship to Patient: Spouse☐ Parent☐ Other☐** _____

Home Phone: ( ) _____ **Work Phone: ( )** _____ **Occupation:** _____

Employer: _____ **Address:** _____

MEDICAL INSURANCE INFORMATION:

Insurance Company Name: _____ **Telephone #:** _____

Claims Address: _____

Type of Insurance: Medical ___ Dental ___ Both Medical and Dental ___ (PPO☐ POS☐ HMO☐ DHMO☐)

Policy ID#: _____ **Group #:** _____ **Plan #:** _____

Policyholder's Name: _____ **SS#:** _____

Date of Birth: _____ **Relationship to Patient: Self☐ Spouse☐ Child☐ Other☐** _____

Employer: _____ **Address:** _____

DENTAL INSURANCE INFORMATION:

Insurance Company Name: _____ **Telephone #:** _____

Claims Address: _____

Type of Insurance: Medical ___ Dental ___ Both Medical and Dental ___ (PPO☐ POS☐ HMO☐ DHMO☐)

Policy ID#: _____ **Group #:** _____ **Plan #:** _____

Policyholder's Name: _____ **SS#:** _____

Date of Birth: _____ **Relationship to Patient: Self☐ Spouse☐ Child☐ Other☐** _____

Employer: _____ **Address:** _____

An estimate of the charge for any procedure or surgery you may require will be given to you. I understand I am financially responsible for payment of all services at the time they are rendered, unless other payment arrangements have been established. Please remember that insurance is considered a method of reimbursing the patient for fees 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, co-insurance or any other balance not paid for by your insurance company.

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by the above physicians and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or charge information as is necessary for third party reimburse from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all charges incurred as well as attorney's fees of 33 1/3% and any other costs of collection should such action become necessary.

Signature of Patient/Responsible Party: _____ Relationship to Patient: _____ Date: _____