

PATIENT INFORMATION

DATE _____

Mr. Mrs. Ms. Dr. First Name _____ Last Name _____ Nickname _____

Male Female Birth Date _____ Age _____ Soc. Sec. # _____ Email _____

Street _____ City _____ State _____ Zip _____

Home Tel. (____) _____ Cell (____) _____ Fax (____) _____

Preferred Contact Method: Home Cell Work Fax Email Other _____

Employer _____ Occupation _____ Bus. Tel. (____) _____

Who referred you to our office? _____

Who will be responsible for the account? Self Spouse Father Mother Other _____

(If self, please skip to next section)

Name _____ S.S.# _____ Birth Date _____
First Last

Street _____ City _____ State _____ Zip _____

Employer _____ Bus Tel. (____) _____

Insurance Information

Married Divorced Separated Widow Single Do you belong to a: PPO HMO No Insurance

Employed: Full Time Part Time Retired N/A

Student: Full Time Part Time N/A School Attending _____

Primary Dental Insurance

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____

Tel (____) _____ Group# _____

Insured Name _____

M F DOB ____/____/____ S.S.# _____

Address _____

City _____ State _____ Zip _____

Employer of the Insured

Address _____

City _____ State _____ Zip _____

Secondary Dental or Medical Insurance

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____

Tel (____) _____ Group# _____

Insured Name _____

M F DOB ____/____/____ S.S.# _____

Address _____

City _____ State _____ Zip _____

Employer of the Insured

Address _____

City _____ State _____ Zip _____

Fees and Payments

We make every effort to keep down the cost of oral surgical care. Payment arrangements can be made with our patient treatment coordinator depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to submit a claim on your behalf, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid 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 charges. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees, and court costs.

Signature of patient _____ Date _____
(Parent or Guardian if Minor)

Authorization

I authorize Dr. Iranmanesh and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of the examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of patient _____ Date _____
(Parent or Guardian if Minor)

HEALTH HISTORY

To our patients: Although Oral Surgeons primarily treat the area in or around your mouth, health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. The following information is confidential and is essential for us to provide you with safe and effective care.

Circle the appropriate answer (Leave BLANK if you do not understand the question)

1. Yes No Are you in good health? Height _____ Weight _____
2. Yes No Has there been any changes in your health within the past year?
3. Yes No Are you under the care of a physician? Date of last visit _____

4. Yes No If yes, what are you being treated for? _____
Do you have any allergies? _____
If yes, please list _____

Are you currently using...

5. Yes No Tobacco products? 6. Yes No Herbal Remedies?
7. Yes No Alcohol? 8. Yes No Recreational Drugs?
If yes, please list _____ If yes, please list _____

Have you had or do you currently have...

9. Yes No A cough or cold? 31. Yes No Diarrhea, constipation, or blood in stool?
10. Yes No Sinus Problems? 32. Yes No Ulcers or other digestive problems?
11. Yes No Bleeding or bruising easily? 33. Yes No Hepatitis or other liver disease?
12. Yes No Difficulty swallowing? 34. Yes No Diabetes?
13. Yes No Asthma? 35. Yes No Swollen ankles?
14. Yes No Vomiting or Nausea? 36. Yes No Excessive Thirst or urination?
15. Yes No TB, Emphysema or other lung disease 37. Yes No Thyroid trouble?
16. Yes No Blood disorder? 38. Yes No Kidney trouble?
17. Yes No Blood transfusion? 39. Yes No Arthritis?
18. Yes No Fainting spells or dizziness? 40. Yes No Tumors or cancer?
19. Yes No Seizures or epilepsy? 41. Yes No Radiation therapy/ chemotherapy?
20. Yes No High blood pressure? 42. Yes No Skin disease
21. Yes No Low blood pressure? 43. Yes No VD (syphilis or gonorrhea)?
22. Yes No Heart murmurs or heart valve disease? 44. Yes No Herpes?
23. Yes No Chest Pains? 45. Yes No AIDS, ARC or HIV positive?
24. Yes No Heart attack? 46. Yes No Eye disease?
25. Yes No Heart surgery? 47. Yes No Contact lens?
26. Yes No Pacemaker? 48. Yes No Artificial joints?
27. Yes No Stroke? 49. Yes No Ringing in the ears?
28. Yes No Rheumatic fever? 50. Yes No Unusual reaction to anesthetics?
29. Yes No A-V Fistula or Shunt? 51. Yes No Hospitalization?
30. Yes No Mental Health problems? 52. Yes No Surgeries?
53. Yes No Do you currently have a removable dental appliance? 55. Yes No If you are planning on have surgery today, have you had anything to eat or drink in the last 8 hours?
54. Yes No Is there pain or clicking in your jaw? 56. Who is driving you home? _____

Is there a family history of:

57. Yes No Cancer?
58. Yes No Diabetes?
59. Yes No Heart Disease?
60. Yes No Anesthetic Problems?

In case of emergency:

Name _____
Tel (_____) _____
Relation to patient _____
Physician Name _____

This section for women only:

61. Yes No Is there a possibility that you are pregnant?
62. Expected delivery date? _____
63. Yes No Are you nursing?
64. Yes No Are you taking birth control pills?

Note: Antibiotics may alter the effectiveness of birth control pills. Consult your Medical physician for assistance regarding additional methods of birth control.

To the best of my knowledge, I have answered every question completely and accurately. I will inform this office of any change in my health and/or medication. I will not hold the surgeon or his staff responsible for any errors that I have made on this form.

Signature of patient _____ Date _____
(Parent or Guardian if Minor)

Medical History Update:

1. Patient Signature _____ no changes changes Date: _____
2. Patient Signature _____ no changes changes Date: _____
3. Patient Signature _____ no changes changes Date: _____