

PATIENT INFORMATION

PERSON FINANCIALLY RESPONSIBLE

Name _____
Birthdate _____ Single Married Widowed Divorced
Address _____
City _____ State _____ Zip _____
Home # _____ Work # _____
Cell # _____ SS# _____
Occupation _____
Employer _____
Address _____

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Dentist Name: _____
Dentist Address: _____
Date of last visit to dentist _____
Referred by name: _____
Referring by address: _____

Physician Name: _____
Physician Address: _____
Do you have Dental Insurance? Yes No
Do you have Major Medical Insurance? Yes No

PATIENT MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health? _____ Yes No

If you are under the care of a Physician, what are you being treated for? _____
If you have been hospitalized in the last 5 years, what was it for? _____

If you have experienced abnormal bleeding after extractions, surgery or trauma, please explain. _____

What drugs or medications are you currently taking? _____

Do you smoke? Yes No If so, how much? _____

Do you have "dry mouth" at night that interferes with your sleep? Yes No

WOMEN Are you pregnant? Yes No Are you nursing? Yes No

Yes No Damaged heart valves/artificial valves/heart murmur _____

Yes No Cardiovascular disease (heart attack) _____

Yes No High Blood Pressure Yes No Stroke

Yes No Asthma Yes No Stomach Ulcers

Yes No Diabetes Yes No Kidney Trouble

Yes No Hepatitis/Jaundice/Liver Disease Yes No Tuberculosis

Yes No Anemia Yes No Low Blood Pressure

Yes No Venereal Disease Yes No Epilepsy

Yes No AIDS or other immunosuppressive disorder Yes No Cancer

Are you allergic to or have you reacted adversely to:

Yes No Local Anesthetics Yes No Penicillin _____

Yes No Sulfa Drugs Yes No Other antibiotics _____

Yes No Barbiturates, sedatives or sleeping pills Yes No Aspirin _____

Yes No Iodine Yes No Codeine or other narcotic _____

Do you have any disease, condition or problem not listed above that you think we should know about? _____

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

Signature of Patient _____ Date _____

Signature of Parent (if patient is a minor) _____ Date _____

**HOCHSTADTER, ISAACSON, CHERNY, DUMANIS & ASSOCIATES
ORAL AND MAXILLOFACIAL SURGERY, LTD**

Insurance is a benefit to you. We will gladly assist you with the filing of your claims. Payment is due when services are rendered, unless other arrangements have been made in advance.

It is the patient's responsibility to know their insurance benefits. If you have any questions regarding your insurance coverage, please call your insurance carrier directly.

Any balance due and owing to the doctors after 60 days shall have a finance charge of 1% per month (12% annually) added every month thereafter, regardless of pending insurance.

The patient and/or guarantor agrees and understands that if the account balance is referred to an outside agency for collection, all costs and fees shall become the responsibility of the patient and/or guarantor and shall be applied to the current balance at the time of placement.

I fully understand that I am solely responsible for my account balance regardless of delays or non-payment by my insurance company.

Guarantor's social security number _____

Guarantor's date of birth _____

Guarantor's relationship to patient _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge that I have received a copy
Print Name Here
of Hochstadter, Issacson, Cherny, Dumanis & Associates' Notice of Privacy
Practices. I have been given the opportunity to ask any questions I may have
regarding this Notice.

Signature _____

Date _____