Oral & Maxillofacial Surgery

Patient's Name: ____
Patient's Address: ____
Phone: ___________________________ **Age:** ________________________________
Patient's Height ____________________ **Patient's Weight** _____________________
Referring Doctor: _________________ **Family Doctor** ________________________

<u>Pre-operative Medical History:</u> Please answer all questions by circling (yes) or (no)

1. **Do you have or have you ever had:**

1. Diabetes…..............	**yes**	**no**	**16. Sleep Apnea……….**	**yes**	**no**
2. Heart Disease……..	**yes**	**no**	**17. Snoring…………….**	**yes**	**no**
3. Heart Attack (MI)…	**yes**	**no**	**18. Scarlet Fever………**	**yes**	**no**
4. Ankle Swelling….	**yes**	**no**	**19. Epilepsy/Seizures…**	**yes**	**no**
5. Shortness of Breath.	**yes**	**no**	**20. Lung Disease/(COPD)**	**yes**	**no**
6. Kidney Disease…...	**yes**	**no**	**21. Tuberculosis……….**	**yes**	**no**
7. Rheumatic Fever….	**yes**	**no**	**22. Asthma…………….**	**yes**	**no**
8. Liver Disease……..	**yes**	**no**	**23. Venereal Disease…..**	**yes**	**no**
9. Anemia…………...	**yes**	**no**	**24. High Blood Pressure**	**yes**	**no**
10. Abnormal Bleeding.	**yes**	**no**	**25. GI Reflux…………..**	**yes**	**no**
11. Recent cold or flu…	**yes**	**no**	**26. Ulcers……………..**	**yes**	**no**
12. Glaucoma…………	**yes**	**no**	**26. Pregnancy…………**	**yes**	**no**
13. Mitral Valve Prolapse	**yes**	**no**	**27. H.I.V/ A.I.D.S…….**	**yes**	**no**
14. Heart Murmur.........	**yes**	**no**	**28. TMJ pain/clicking...**	**yes**	**no**
15. Thyroid Disease…...	**yes**	**no**	**29. Joint Replacement...**	**yes**	**no**

2. Are you under a physician's care? ____ Reason ____________________________

3. List previous hospitalization / operations ___________________________________

4. Are you currently pregnant? ______ Do you have an allergy to **Latex**? __________

5. Do you have any allergies to **medications**? ______ Please list _______________

6. Are you presently on medications? **(Please list all medications including over the counter medications, Herbal Supplements, Inhalers, Insulin, Birth Control, Diet Pills, etc.) Please list dose and frequency below.**

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1. ________________________________ 4. ________________________________

2. ________________________________ 5. ________________________________

3. ________________________________ 6. ________________________________

See Next Page

7. Have you ever had radiation therapy or chemotherapy for cancer? yes no

8. Have you ever had general anesthesia? (i.e. sleep) yes no
Complications: ____

9. Have you ever had local anesthesia? (i.e. Novocaine) yes no
Complications: ____

10. Do you wear contact lenses? yes no

11. Do you smoke? If so, how much?___________________________________

12. Do you drink alcohol? If so, how much?______________________________

13. Do you use any "street" drugs (i.e. Cocaine, Heroin, Ecstasy or Marijuana?) yes no

14. Have you had any past treatment for chemical dependency or alcoholism? yes no

15. Have/are you being treated for an eating disorder (i.e. anorexia / bulimia)? yes no

16. What brings you to our office today? (Chief complaint) ____________________

17. With previous surgeries, have you experienced:

A. Abnormal bleeding? _______ B. Infection? ________ C. Delayed Healing?________

D. Other complications? ____

I understand the importance of a truthful health history to assist the Doctor in providing the best care possible. I have answered the above questions to the best of my knowledge.

Signature: ____Date:_________
(Patient Signature)

Signature: ____Date:_________
(Doctor Signature)

Medication Record Form

Patient Name ______________________ Date ______________

Date of Birth ______________________

Allergies ______________________

Current Medication List

Medication	Dose	Route	Frequency	Reason for taking

Patients Signature ______________________

FOR OFFICE USE: Date ______________

Meds Prescribed by Dr. ______________________

	Medication	Dose	Route	Frequency	Reason for taking
☐	Amoxicillin	875mg	Mouth	2 x Daily	Antibiotic
☐	Azithromycin	Z-Pack	Mouth	As Directed on pk	Antibiotic
☐	Vicodin	5/500mg	"	1 Tab Every 4-6h	Pain
☐	Vicodin	7.5/750mg	"	1 Tab Every 4-6h	Pain
☐	Percocet	5/325mg	"	1 Tab Every 4-6h	Pain
☐	Chlorhexidine	0.12%	"	2 x Daily	Antimicrobial Rinse
☐	Medrol	Dose pk	"	As Directed on pk	Swelling
☐	Sock-It	Gel	"	Every 4-6h	Discomfort / Wound Healing
☐			"		

May resume held meds ______________________

☐ Monoject Syringe Given
☐ Sinus Precautions Inst.
☐ Flonase / Nasonex
☐ Claritin-D (OTC)

Patient/Escort Sig. ______________________

Rev. with patient/escort by: ______________________ Date ______________

Oral & Maxillofacial Surgery

Office Financial Policy

Your healthcare is extremely important to us. To continue to give you the best care possible it is important to help us maintain our records and keep our accounts current.

For elective and implant surgeries, we require one-half of the total fees to be paid at the time you schedule your surgery. This is required in order to hold the date that you choose. For your convenience, we gladly accept MasterCard, Visa and Discover. In addition, Western Reserve Center has outside credit lenders to assist with borrowing additional money. We do not accept personal checks as payment at the time of service.

If you have insurance that will be covering your charges, we will gladly assist you in any way we can. To do so we ask you to pay for the portion of the charges not covered by your policy, i.e. deductible, co-pays, and non-covered charges at the time of service; or in the case of surgery, prior to the time of the surgery. If we are out of network, we require you to pay for the services at time rendered and we will help you file your claim for payment to your insurance for reimbursement. You are responsible for payment for your treatment. Your insurance policy is a contract between you and your insurance company. We cannot guarantee third party payment for your claims. Many procedures may require pre-authorization prior to surgery. This may delay the planned procedure and other payment arrangements may need to be made if the procedures are done prior to the written pre-authorization.

It is very important to understand that we care very much for our patients and give them our complete attention. Your appointment is exclusive for you. If you break the appointment, or simply forget it, we do not have another patient for that time slot. We take that risk for you because we know your time is valuable, so please remember ours is too.

There will be a $35.00 charge for all checks returned to us. All delinquent accounts will be handled according to collection agency policies. In addition, a "no-show" policy will be enforced. Thank you for your consideration.

Signature: ______________________________________ Date: _____________

Western Reserve Center Patient Registration

Cell Phone:_________________________________

Date: ___________________________________ Work Phone: _______________________________

Patient Information

Name: __________________________________ Social Security # ___________-________-____________

Address: ____

City: __________________________ State: __________________ Zip: _____________________________

Sex: M F Age:__________ Birthdate: _____________ Marital Status: ________________________

Employer's Name: __________________________________ Occupation: __________________________

Whom May we thank for referring you? ____

Incase of emergency who should be notified? ____

Phone: ___________________________ Business Phone: ______________________________________

Email Address: ___________________________________

Primary Medical Insurance

Person responsible for Account: ____

Relation to Patient: ______________________ Birthdate: _____________S. S. # ______-______-______

Address (if different to patient's) ____

City: ___________________________ State: ______________ Zip: __________ Phone: ______________

Person Responsible Employed By:_______________________ Business Phone: ___________________

Insurance Company Name: ____

Group # ______________________________ Subscriber # ______________________________________

Primary Dental Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name: ________________________Relation to Patient: _________ Birthdate: ___________

Insurance Company: ___________________________ Group # ___________________________________

Subscriber # ________________________________ Insurance Phone # ____________________________

Oral & Maxillofacial Surgery

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request and authorize the release of all information, without limitations regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes medical-dental history, x-ray findings, diagnosis, prognosis and access to all hospital records and photocopies of the same.

I request that you release the above information to:

____
Doctor

____
Address

____
City State Zip

Requesting: ______________________________________

____
Patient's Name

____
Patient's Birthday Patient's ID Number

____
Patient's Signature Date

____
Witness' Signature Date

Oral & Maxillofacial Surgery

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

The Western Reserve Center for Oral & Maxillofacial Surgery is required to provide you with a copy of the Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this Form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

Patient Name: ______________________________ (print)

Additional information requested:

At which of the following number(s) do we have permission to contact or leave messages for you regarding your treatment, medication or financial/insurance information?

Home ___ - ___ - _____ Cell _____-______-_____ Work ___ - ___ - _____

Other than your insurance carrier, who may we speak with about your healthcare information?

Spouse Name ____________________ Phone ____________________

Child Name ____________________ Phone ____________________

Parent Name ____________________ Phone ____________________

Other Name ____________________ Phone ____________________

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and I have had an opportunity to review it.

___________________________ ________________________

Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

O The patient refused to sign.
O Due to an emergency situation it was not possible to obtain an acknowledgment.
O We are not able to communicate with the patient.
O Other (Please provide specific details). ______________________________

Employee Signature ___________________________________ Date ___________________

Oral & Maxillofacial Surgery

Patient Interest Questionnaire

Patient Name: ______________________________ Date: ___________

I. Please indicate the following services, products, procedures and/or health issues of interest to you. (Please check all the boxes that apply.)

- o Dental Implants
- o Oral Surgery, please specify:________________________
- o Corrective Jaw Surgery
- o Facial Contouring/Facial Implants
- o Rhinoplasty/Prominent Nose
- o TMJ Therapy
- o Botox treatments for facial frown lines
- o Lip Augmentation
- o Restylane/Juvederm: volume replacement therapy for wrinkles
- o Cosmetic Surgery of the Body
- o Cosmetic Surgery of the Face

II. Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

a. When looking at my face/mouth/teeth in the mirror, I believe I look younger, the same as, or older than my true age.

Younger than		True Age		Older Than
1	2	3	4	5

b. When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my face/mouth/teeth.

Younger Than		True Age		Older Than
1	2	3	4	5

III. How did you hear about us?

- o My dentist/physician (name): ____________________________
- o The Yellow Pages (specify advertisement): ____________________
- o Internet (please list website):____________________________
- o Friend or Family Member (name): __________________________
- o Insurance (name): ______________________________________

Patient Signature: ____