WELCOME TO OUR PRACTICE

PATIENT INFORMATION

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name _________________ M.I.___ Last Name____________________ Nickname_______________

Sex: ☐Male ☐Female Birth Date _____________ Age_________ Soc. Sec. #______________________ Email _________________

Address __________________________________ Apt. ________City ___________________ State ________ Zip Code_______________

Home Tel. ( ) ___________________ Cell ( ) _____________________ Have you ever been a patient of our practice? ☐Yes ☐No

Referred By ___________________________ Dentist _____________________________ Medical Doctor ________________________

Employer: ________________ Ph. ( ) ________________ Emergency Contact _____________________ Ph. ( )_________________

WHO WILL BE FINANCIALLY RESPONSIBLE FOR YOUR ACOUNT? (if self, mark self and skip to next section)

☐Self ☐Spouse ☐Mother ☐Father ☐Other ______________________________

Name __________________________________ SSN: _______________________ DOB ____________ Phone ( )__________________

Address _________________________________ City __________________________ State ________ Zip Code ______________________

Employer ______________________________ Business Phone No. ( ) __________________________

INSURANCE INFORMATION

Are you (the patient) a student? ☐Yes ☐No Name of School ____________________________ ☐Full Time ☐Part Time

Are you (the patient) employed? ☐Yes ☐No ☐Retired

PRIMARY DENTAL INSURANCE

Name of Ins. ____________________________ Policy ID No./SSN __________________________ Employer __________________

Subscriber's Name ___________________________ Subscriber's DOB _______________ Relationship to Patient _____________

SECONDARY DENTAL INSURANCE

Name of Ins. ____________________________ Policy ID No./SSN __________________________ Employer __________________

Subscriber's Name ___________________________ Subscriber's DOB _______________ Relationship to Patient _____________

PRIMARY MEDICAL INSURANCE

Name of Ins. ____________________________ Policy ID No./SSN __________________________ Employer __________________

Subscriber's Name ___________________________ Subscriber's DOB _______________ Relationship to Patient _____________

SECONDARY MEDICAL INSURANCE

Name of Ins. ____________________________ Policy ID No./SSN __________________________ Employer __________________

Subscriber's Name ___________________________ Subscriber's DOB _______________ Relationship to Patient _____________

FEES, PAYMENTS, AND AUTHORIZATION

Fees are due upon completion of each visit. 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 fill out the proper forms, but we will require you provide us with the identifying insurance 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. It is your responsibility to pay any coinsurance, deductible, and/or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, court costs, and bounced check fee of $20 (if your check is returned from the bank for insufficient funds).

I authorize release of information necessary to process my claim(s). I hereby authorize payment to Dr. Norbert Fernandez otherwise payable to me. I authorize Dr. Fernandez and his staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. In addition, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I also authorize the release of any information acquired in the course of my examination and treatment.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions that I have regarding this Notice. I understand and agree to all of the above.

Signature of Patient: ____ Date _________________________________

(Parent or guardian if minor)

HEALTH HISTORY QUESTIONAIRRE

To our Patients: Health problems you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving here. It is important that you answer these questions in their entirety and we thank you for doing so.

Have there been any changes in your general health in the past year? ☐Yes ☐No Height __________ Weight__________

Are you under the care of a physician? ☐Yes ☐No *If yes, what are you being treated for?*______________________________

Have you had any illness, operation, or been hospitalized in the past five years? ☐Yes ☐No

If yes, please describe ____

Do you have any unhealed/recurrent injuries and/or inflamed areas, growths, or sore spots in or around your mouth?

☐Yes ☐No *If so, please describe where* ____

Do you have a prosthetic joint/implant? ☐Yes ☐No - Have you had a heart valve replacement or vascular graft? ☐Yes ☐No

Do you take antibiotics prior to dental procedures ☐ Yes ☐No *If yes, what antibiotic do you take?* ______________________

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	Yes	No	Notes	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	Yes	No	Notes
Rheumatic fever?				Fainting spells?			
Damaged heart valves/MVP?				Convulsions/epilepsy?			
Heart murmur?				Stroke?			
High blood pressure?				Thyroid trouble?			
Low blood pressure?				Diabetes?			
Chest pain/angina?				Low blood sugar?			
Heart attack(s)?				Kidney trouble?			
Irregular heart beat?				Are you on dialysis?			
Cardiac pacemaker?				Osteoporosis/Osteopenia?			
Heart Surgery?				Osteonecrosis?			
Pneumonia, bronchitis, chronic cough?				Stomach ulcers?			
Asthma?				Contagious diseases?			
Hay fever/sinus problems?				Sexually transmitted diseases?			
Snoring/sleep apnea?				Problems with your immune system?			
Difficulty breathing/other lung trouble?				A tumor or growth?			
Tuberculosis?				Cancer/radiation/chemotherapy?			
Emphysema?				History of drug abuse?			
Do you smoke? If so, # of packs a day _______				History of alcohol abuse?			
Do you use chewing tobacco?				Contact lenses?			
Blood transfusion?				Eye disease/glaucoma?			
Blood disorder such as anemia?				Mental health problems?			
Bleeding tendency/abnormal bleeding?				Pain and clicking of jaws when eating?			
Hepatitis, jaundice, or liver disease?				Have you, or a family member had any unusual or serious reactions to general anesthesia?			
Infectious mononucleosis?							

HEALTH HISTORY QUESTIONAIRRE

MEDICATION – Are you now taking?	Yes	No	Notes	ALLERGIES – Are you allergic to or had a reaction to….	Yes	No	Notes
Blood thinners (Coumadin, Plavix, aspirin)				Local anesthesia			
				Latex			
Any natural product, herbal supplement, or homeopathic remedy				Penicillin			
				Amoxicillin			
				Other antibiotics			
Have you ever taken bone density medication/bisphosphonates such as Fosamax, Zometa, Actonel?				Sulfa drugs			
				Sodium pentothal/Valium/other Tranq.			
				Aspirin			
Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis?				Sulfites			
				Codeine or other narcotics			
				Other medications (please list)			
Any other medications? If yes, please list below:				Eggs/Yolk			
				Soy			

MEDICATION LIST

Medication	Dosage	Frequency

THIS SECTION IS FOR WOMEN ONLY

Is there a possibility of pregnancy ☐ Yes ☐ No
Expected delivery date _____/_____/_____
Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No
Please Note: Antibiotics (such as amoxicillin) may alter the effectiveness of birth control pills. Please consult your physician.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Name (please print) ________________________________

Signature of Patient: ___________________________________ Reviewed By: __________________________ Date __________
(Parent or Guardian if minor)