

Carolinas Center for Oral & Facial Surgery

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Nickname: _____ Last Name: _____
Sex: Male _____ Female _____ Date of Birth: _____ Age: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
PO Box or Apartment # _____ Email address: _____
Telephone: Home: (____) _____ Work: (____) _____ Cell: (____) _____
Marital Status: S M W D If Student: Full Time _____ Part Time _____ Name of School _____
Emergency Contact Name _____ Relationship: _____ Phone Number: (____) _____
Primary Physician: _____ Phone Number: (____) _____
Dentist: _____ Orthodontist: _____ Referred by: _____
How did you choose our practice: Referral _____ Location _____ Insurance _____ Relatives/Friends _____
Has a member of your family been seen in our practice? Who? _____

If you are under 18 or a full-time college student, please complete the following information:

Mother's Name: _____ Telephone: (H) (____) _____ (W) (____) _____
Address: _____ Mother's Social Security #: _____
Father's Name: _____ Telephone: (H) (____) _____ (W) (____) _____
Address: _____ Father's Social Security #: _____
Who came with you to the appointment today? _____ Mother _____ Father _____ Other _____

PRIMARY MEDICAL INSURANCE

Insurance Company: _____
Address: _____
Phone #: _____
Policy #: _____ Group #: _____
Name of Insured (Policyholder): _____
Insured's Address: _____
Insured's Phone: (H) _____ (W) _____
Insured's Employer: _____
Insured's Date of Birth: _____
Insured's Social Security #: _____
Patient's Relation to Insured: Self Spouse Child Other

SECONDARY MEDICAL INSURANCE

Insurance Company: _____
Address: _____
Phone #: _____
Policy #: _____ Group #: _____
Name of Insured (Policyholder): _____
Insured's Address: _____
Insured's Phone: (H) _____ (W) _____
Insured's Employer: _____
Insured's Date of Birth: _____
Insured's Social Security #: _____
Patient's Relation to Insured: Self Spouse Child Other

PRIMARY DENTAL INSURANCE

Insurance Company: _____
Address: _____
Phone #: _____
Policy #: _____ Group #: _____
Name of Insured (Policyholder): _____
Insured's Address: _____
Insured's Phone: (H) _____ (W) _____
Insured's Employer: _____
Insured's Date of Birth: _____
Insured's Social Security #: _____
Patient's Relation to Insured: Self Spouse Child Other

SECONDARY DENTAL INSURANCE

Insurance Company: _____
Address: _____
Phone #: _____
Policy #: _____ Group #: _____
Name of Insured (Policyholder): _____
Insured's Address: _____
Insured's Phone: (H) _____ (W) _____
Insured's Employer: _____
Insured's Date of Birth: _____
Insured's Social Security #: _____
Patient's Relation to Insured: Self Spouse Child Other

I authorize Carolinas Center for Oral & Facial Surgery to release any information for insurance purposes. I hereby authorize payment directly to Carolinas Center for Oral & Facial Surgery.

Signature of Patient or Responsible Party: _____ Date: _____

I certify that the information on this form is correct. I understand that I am responsible for any balance on this account, even if I have medical and/or dental coverage.

Signature of Responsible Party: _____ Date: _____

MEDICAL HISTORY

Name of Patient _____

Age: _____

Weight: _____

- 1. Are you allergic to any medicines or latex? (list below)..... Yes No

- 2. Are you allergic to eggs or soybean oil? Yes No
- 3. Do you take any medication or herbal therapy regularly now? Yes No
List Name, Strength & Frequency of current medications: _____

- 4. Are you or have you taken medication for decreased bone density? (list below) Yes No

- 5. Have you taken any kind of medication regularly during the past year? (list below) Yes No

- 6. Have you been a patient in a hospital during the past 2 years?..... Yes No
- 7. Are you now or have you been under the care of a physician during the past 2 years?..... Yes No
- 8. Have you ever had any type of surgery? (list below)..... Yes No

9. **Circle YES or NO as to whether you now have or in the past have had problems with and/or treatment for:**

- | | | |
|--|---------------------|-------------------------------|
| YES NO Heart Trouble | YES NO Asthma | YES NO Arthritis |
| YES NO Congenital Heart Lesions | YES NO Breathing | YES NO Stroke |
| YES NO Heart Murmur | YES NO Diabetes | YES NO Epilepsy |
| YES NO High or low blood pressure | YES NO Tuberculosis | YES NO Psychiatric Treatment |
| YES NO Anemia | YES NO Hepatitis | YES NO Sinus Trouble |
| YES NO Rheumatic fever | YES NO Jaundice | YES NO Kidney Trouble |
| YES NO Drug Use | YES NO Alcohol Use | YES NO Immune System Disorder |
| YES NO Temporomandibular Joint (TMJ) Disorders | | |

OTHER: _____

- 10. Have you ever had any excessive bleeding requiring special treatment?..... Yes No
- 11. If female, are you pregnant?..... Yes No
- 12. Has your physician recommended prophylactic antibiotics prior to dental treatment?..... Yes No
- 13. Have you ever had any artificial joint placed?..... Yes No
- 14. Do you use or have you used tobacco products?..... Yes No
- 15. Do you have a history of alcohol abuse?..... Yes No
- 16. Do you have any medical or dental problems that you think I should know about? (list below) Yes No

SIGNATURE (of patient or legal guardian) _____ **DATE:** _____

FOR OFFICE USE: Reviewer _____ Date: _____

Comments _____

Update _____

Date _____