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_____