

WELCOME! Thank you for selecting Tribeca Oral and Maxillofacial Surgery. This information is necessary for our files and will be considered CONFIDENTIAL

Patient's Name _____ Social Security Number _____
LAST FIRST INITIAL

Nickname _____ Sex M F Age _____ Patient's Birthdate _____

If patient is a minor, give name of parent or legal guardian _____ Relationship _____

Residence Address _____ Residence Phone () _____
STREET Apt. CITY ZIP

Patient is: Married Single Divorced Separated Widowed Minor

Employed by _____ How long? _____ Occupation _____

Business Address _____ Business Phone () _____
STREET CITY ZIP

Spouse's Name _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ Business Phone () _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Residence Phone () _____
STREET CITY ZIP

Name of Physician _____ CITY TELEPHONE
ADDRESS

Name of Dentist _____ CITY TELEPHONE
ADDRESS

Purpose of Appointment _____

Whom may we thank for referring you? _____

FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address (if different from above) _____
STREET CITY ZIP TELEPHONE

Preference of Payment: Cash on day of treatment Bank Charge Card _____

Name of insurance company _____

NAME OF INSURED BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.
GROUP NO. NAME OF UNION LOCAL

DO YOU HAVE ADDITIONAL INSURANCE? YES NO IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insurance company _____

NAME OF INSURED BIRTHDATE RELATIONSHIP SOCIAL SECURITY NO.
GROUP NO. NAME OF UNION LOCAL

TERMS AND CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency services, or any service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand that services furnished to me are charged directly to me and that I am personally responsible for payment of all services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to my doctor benefits accruing to me under my policy.

A service charge of 1 1/2% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for treatment can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: _____ Date: _____

Health Questionnaire

Please answer each question.

MEDICAL HISTORY

- Are you in good health?Yes _____ No _____
- Date of last physical examination _____
- Are you now under the care of a physician?Yes _____ No _____
If so, what is the condition being treated? _____
- Have you ever had any serious illness or operation?Yes _____ No _____
If so, what illness or operation? _____
- Have you ever been hospitalized?Yes _____ No _____
If so, what was the problem? _____
- Are you taking any medication?Yes No or any recreational drugs (marijuana, cocaine, etc.)?Yes No
If so, what? What dosage? _____ How Often? _____
- Are you sensitive or allergic to any drugs? Penicillin Yes No Tetracycline Yes No Aspirin Yes No Codeine Yes No
Other Yes No If Other, which drugs? _____
- Do you have or have you had any of the following: (Please check known conditions - Y box for YES, N box for NO)

- | | | | | | |
|--|---|--|--|---|---|
| Y N | Y N | Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> X-Ray or Cobalt Treatment |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Fainting Spells or Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Tuberculosis (T.B.) | <input type="checkbox"/> Radiation Treatment of any kind |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis or Jaundice |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty in Swallowing | <input type="checkbox"/> TMJ (Temporomandibular joint) Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Ailments or Attack | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> AIDS Related Complex | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Phen-Fen Medication | |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Artificial Prosthesis | | | |

If yes, has your physician ever told you that you must take preventative antibiotics for your dental treatment? Yes _____ No _____

- Do you wear a cardiac pacemaker, or have you had heart surgery?Yes _____ No _____
- Do you have any disease, condition or problem not listed that you think we should know about?Yes _____ No _____
If so, what? _____
- Do you smoke? If yes, how much? _____ per dayYes _____ No _____
- (Women) Are you pregnant? If so, how many months _____Yes _____ No _____
- (Women) Do you have any problems associated with your menstrual period?Yes _____ No _____
- (Women) Do you take birth control pills?Yes _____ No _____

DENTAL HISTORY

- Have you ever had any unfavorable reaction from a local anesthetic?Yes _____ No _____
- Have you had any serious trouble associated with any previous dental treatment?Yes _____ No _____
- If so, explain _____
- Do your gums bleed when you brush?Yes _____ No _____ Are your teeth sensitive to pressure?Yes _____ No _____
- Do you grind or clench your teeth?Yes _____ No _____ Do you have any fear of dental work?Yes _____ No _____
- Date of last examination or treatment _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will inform the doctor at my next appointment.

Date _____ Signature _____

Year 2
Changes in Health _____

Date _____ Signature _____

Year 3
Changes in Health _____

Date _____ Signature _____

Health Questionnaire MUST be updated every year!

RENEWED BY	DO NOT WRITE IN THIS SPACE		
	YEAR 1	YEAR 2	YEAR 3
	Date	_____	_____
	BP	____/____	____/____
YEAR 2	Pulse	_____	_____
YEAR 3	Temp	_____	_____
	By	_____	_____