



Patient Information

Reason for visit

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Teeth extractions | <input type="checkbox"/> Dental implants | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> Bone grafting | <input type="checkbox"/> Exposure of teeth | <input type="checkbox"/> Biopsy |
| <input type="checkbox"/> Jaw surgery | <input type="checkbox"/> Pain and swelling | <input type="checkbox"/> Follow up |
| <input type="checkbox"/> CT scan | | |

Other

Patient Information

Patient's name *

Street Address *

Patient's E-mail *

Address Line 2

Date of birth *

 / /

(MM/DD/YYYY)

City *

State *

Referred by *

Zip Code *

Name of your general dentist

Country

Telephone number *

Which is your preferred way to contact?

- Email Text Cell Home Work

Alternate phone



Financial Guarantor Information

If self, check box and click on Continue

Self Spouse Parent Other

Name *

City *

Date of birth *

 / /

(MM/DD/YYYY)

State *

Phone number *

Zip Code *

Street Address *

Country

Address Line 2

Consultation Authorization

All surgeries require an initial evaluation which consists of clinical and X-ray examination, review of treatment options, and important instructions. A consultation may be done on the same day as surgery for some procedures. The consultation fee is due on the day of the appointment and may or may not be covered under insurances. Please initial below to consent for consultation:

Consultation (\$150)

X-ray Authorization

Most procedures, including wisdom teeth extractions and dental implants, require a panoramic x-ray for diagnosis. This x-ray must be current (within 6 months of surgery). The x-ray fee is due at the time of service and may or may not be covered under insurances. Please initial below to consent for x-ray:

Panoramic x-ray (\$135) Periapical x-ray (\$35) Cone Beam CT (\$275)



Medical History

Sharing accurate medical history is important for safe delivery of your care.

Patient's name *

Patient's E-mail *

Weight

 (Lb.)

Height

 (Ft.) (In.)

Are you currently under care of a physician for any illnesses?

No Yes

If Yes - Please list the conditions:

Have you had serious illness, operation, or hospitalization within the past 5 years?

No Yes

If Yes - Please explain:

Do you have any of the following? (Please check)

- | | |
|--|---|
| <input type="checkbox"/> Artificial joint replacement (knee, hip, shoulder, etc) | <input type="checkbox"/> Serious congenital heart condition |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Infective endocarditis |
| <input type="checkbox"/> Heart murmurs | <input type="checkbox"/> Damaged heart valves |



Do you have or have you had any of the following diseases or problems? (Please check)

- | | | |
|---|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Congenital heart deformities | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> AIDS or AIDS related complex | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Organ transplants | <input type="checkbox"/> Immune deficiency |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irradiation in head/neck region |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Breathing/Respiratory problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cancer |

Are you taking or have you ever taken Bisphosphonates (Fosomax, Actonel, Boniva, Aredia or Zometa) for osteoporosis or chemotherapy for multiple myeloma or other cancers?

- No Yes

If Yes - please explain when you started and stopped therapy.



Do you currently take any medications?

No Yes, I am taking the following medications:

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood thinners (anticoagulants) |
| <input type="checkbox"/> Medications for blood pressure | <input type="checkbox"/> Steroids (including prednisone) |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Ibuprofen (advil, motrin, acetaminophen, tynenol) |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Digitalis |

List any other medications:

Do you have any allergies to medications, substances, or materials?

No Yes, I have allergy to the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Latex or rubber products | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Other antibiotics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Other |

If Other, please specify

Do you smoke?

No Yes

If yes - how much daily?

WOMEN

Are you pregnant or trying to become pregnant?

No Yes

Are you nursing?

No Yes

Are you taking oral contraceptive / hormonal therapy?

No Yes



About form and information given

Form completed by

(first name) (last name)

Relationship to patient

Self Parent Son or daughter Siblings Legal guardian Friend

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 other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

DATE

 (MM/DD/YYYY)

HIPAA

Acknowledgement of Receipt of Notice of Privacy Practices (You may refuse to sign this acknowledgement)

I, * (full name)

have received a copy of this office's Notice of Privacy Practices

Consent for Testing: In order to comply with the Occupational Safety & Health Administration (OSHA) Bloodborne Pathogen Regulation and Maryland State Law, we are requesting your consent to submit to testing of your blood for bloodborne pathogens (hepatitis B, hepatitis C & HIV) if an exposure occurs (needlestick injury, blood spatter) to one of the staff. Testing will be done at no cost to you. All information regarding an exposure is confidential.

Agree Decline

SIGNATURE _____

* (first) * (last)

DATE

 (MM/DD/YYYY)