

PATIENT	INFORM	IATION															
Mr. Mrs	s. Ms.	Dr. Legal	First N	ame					MI		Last	Name	•				
Gender	🛛 Male	🛛 Fema	le 🛛	Other				Birth	Date			Ag	ge	Soc	ial Secu	urity #	
Address						City							State			ZIP Code	
Preferred Na	ame					Home	Phone					Cel	l Phone				
Email										Prefer	red Fo	orm of	Contac	t			
Marital Statu	us		Married		Div	orced			Lega	lly Sep	arated	1		Widow			bingle
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Address						City							State			ZIP Code	
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Dentist Nam	ne											Tele	phone				
Medical Doc	ctor											Tele	phone				
Orthodontis	t											Tele	phone				
Referred By	,																
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Primary Tele	ephone						Relation	onship	to Pa	tient							
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Primary Pol	icy Holder	First		Last				Pri	mary	Policy	Holde	r _{Fi}	irst		L	.ast	
Relation				Gender	🗆 Ma	le 🗆	Femal	e Re	lation					Ger	nder	Male	Female
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Group #			Policy	/ ID #				Gro	oup #					Policy	ID #		
Do you have secondary insurance? Yes No If yes, is it: Medical Dental																	
						Rel	Relation										
Birth Date								S.S	6. #								
Secondary I	nsurance	Co.						Pol	licy ID	#							
Address						City							State			ZIP Code	
Telephone																	



HEALTH HISTORY											
Please answer the following questions carefully and honestly. The information you provide is confidential and will assist us in providing you the best possible care. Please explain any YES answers.											
Do you smoke, chew tobacco or vape? Yes No Per day? Per week?											
Do you smoke marijuana? I Yes I No Per day? Pe											
Do you use alcohol? I Yes I No Per day? Per week?											
Hospitalizations and/or prior surgeries from childhood forward?											No
If yes, please describe when/why											
Reactions to any type of anesthesia?										No	
If yes, please describe											
Any condition you wish to speak privately	Any condition you wish to speak privately about with the Doctor?										No
Any disease or treatment that has lowered your immune system?										No	
Any form of cancer?									Yes		No
Any unpleasant effect from previous dental care?									No		
Are you required to pre-medicate with an antibiotic prior to dental treatment?									Yes		No
If yes, please state why											
MEDICATIONS											

Please list all current prescription medications, non-prescription medications, vitamins, herbal supplements.

ALLERGIES/REACTIONS

Please list any allergies such as latex, codeine, penicillin, Novocain, tape, soy, eggs, nuts.

FOR WOMEN ONLY									
Are you pregnant or trying to become pregnant? Yes No Are you taking birth control pills? Yes						No			
Are you nursing?		Yes		No	Are you taking hormone replacement?		Yes		No
WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.									



Ves No High Blood Pressure Image: Stress and St		
Anxiety HV Appetite Disorder Harseness Arthritis HPV Artificial Joints Intestinal Disorder Astma Jaw Joint Pain/Noise Bleeding Disorder Liver Disorder Bronchitis Measles Chicken Pox Mumps Chicken Pox Mumps Chronic Nasal Congestion Nervous System Disorder Couradin/Blood Thinners Night Sweats Dapression Osteoprosis Medication Diabetes Pneumonia Distocted Joints Radiation Thrapy Dizziness Recent Fevers Earache(s) Recurrent Mouth Sores Emphysema Siourees Fainting Spells Shortness of Breath Fractured Bones Stomach Ulcors Glaucoma Stomach Ulcors Heart Murrur Treated for Alcohol Dependency Heart Valve Replacement Treated for Drug Dependency Heart Valve Replacement Treated for Drug Dependency Heart Valve Replacement Treated for Drug Dependency Heart Valve Replacement Wear Glasses/Contacts <t< th=""><th>Yes</th><th>No</th></t<>	Yes	No
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Patient Signature (Parent or Guardian if minor):	ecessary, for m	iy treatment.
IF PATIENT IS A MINOR		

Form signed by



ACKNOWLEDGMENT OF ANESTHESIA & MEDICATION USE IN YOUR CARE Please initial your understanding and acknowledgment of this policy below.

I acknowledge that certain medications that may be prescribed to me by my doctor at Northeast Oral Surgery and Dental Implant Center may alter my state of mental awareness and decision making. Depending on the type of anesthetic given, I understand the importance of adhering to the following:

- Refrain from driving a car.
- Refrain from operating machinery of any kind.
- Refrain from making important personal or business decisions.
- Refrain from drinking alcohol of any kind.
- Refrain from taking sedatives (prescribed by another doctor or over-the-counter).
- Refrain from taking different medications at the same time. To avoid nausea, wait 30-60 minutes between taking each medication.

PATIENT FINANCIAL POLICY Please initial your understanding and acknowledgment of this policy below.

By initialing below, I agree to the terms of the Patient Financial Policy document.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies for their Protected Health Information (PHI). Additionally, this act provides for an individual to designate person(s) they are associated with, such as parent, guardian, spouse, child, etc. (this is in addition to their personal physician or dentist) to have access to their PHI. I hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices. I give my permission to discuss this account to the following:

1.

2.

INSURANCE REFERRAL WAIVER Please initial your understanding and acknowledgment of this policy below.

I have been informed by Northeast Oral Surgery and Dental Implant Center that based on the rules and regulations of my insurance policy; it is my responsibility to have a referral in place with my medical insurance company from my primary care physician.

I understand that if I do not have a referral in place, claims submitted by Northeast Oral Surgery and Dental Implant Center may not be paid and will be my financial responsibility.

Patient Signature	(Parent or Guardian if minor):			Date				
IF PATIENT IS A MINOR								
Form signed by			Relationship to Patient					