Oral and
Facial Surgery

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Practice Limited to Oral and Maxillofacial Surgery

PATIENT INFORMATION

Patient's **full** name_____

Sex _____ Date of Birth_____ Age _____ Weight _____ SS#_____

Patient's address_____

Phone_____ Employer_____ Work Phone_____

Family Dentist_____ Physician_____

Name of person financially responsible_____

Relationship to patient_____ Employer_____

Address_____

Phone_____ Drivers Lic.#_____ SS#_____

Reason for today's visit (if accident, please give date and description)_____

_____

INSURANCE INFORMATION

Full name of insured_____ Relationship_____

Address of insured_____

Phone_____ Date of Birth_____ SS#_____

Insured's employer_____ Work Phone_____

Insured's employer address_____

Name of **medical** insurance company_____

Address of medical insurance company_____

ID#_____ Group # _____ Policy #_____

Name of **dental** insurance company_____

Address of dental insurance company_____

ID#_____ Group # _____ Policy #_____

Name of secondary insurance company (**medical or dental**)_____

Address of secondary insurance company_____

Insured's name_____ Relationship_____ Employer_____

ID#_____ Group #_____ Policy #_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am fully responsible to the Doctor for the entire fee. I authorize payment of any insurance benefits directly to the Doctor. I authorize the use of this form on all insurance submissions. I, hereby, understand that all unpaid balances over 90 days will be subject to finance charges of 1 ½ % compounded monthly (not to exceed 18% per year).

Signature of person financially responsible_____ Date_____

Answer each question "YES" or "NO". If unknown, leave blank - these will be discussed with you.

Y	N	DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS?
		1. Have you had any changes in your general health in the last year?
		2. Rheumatic fever or rheumatic heart disease?
		3. Birth defects (deformity)?
		4. Glaucoma?
		5. Cardiovascular disease Circle any that apply *(heart trouble, heart attack, high or low blood pressure, arteriosclerosis, heart murmur, stroke, chest pains, shortness of breath)*?
		6. Has any doctor ever told you to take antibiotics before dental treatment?
		7. Do your ankles swell or do you require extra pillows when asleep?
		8. Asthma or hay fever?
		9. Hives or a skin rash?
		10. Fainting spells, seizures or Epilepsy?
		11. Rheumatism (painful swollen joints) / Arthritis?
		12. Diabetes?
		13. Hepatitis, jaundice, or liver disease?
		14. Stomach ulcers?
		15. Kidney trouble?
		16. Thyroid trouble?
		17. Tuberculosis or any other lung disease?
		18. Do you have a persistent cold, cough, or cough up blood?
		19. Venereal disease (bad blood)?
		20. Do you have Sickle Cell Anemia or Trait?
		21. Have you had surgery or treatment for a tumor, growth, broken bone, or other condition?
		22. Are you taking any drug or medicine? If so, what?
		23. Are you under special physician's orders?
		24. Are you allergic or sensitive to any medication? If yes, please list below
		25. Have you had problems or abnormal bleeding with any previous dental treatment?
		26. Do you have any disease, condition, or problem not listed above?
		27. Hospitalized in the last five years?
		28. Have you ever been treated for emotional problems or nerves?
		29. Do you ...smoke? Yes____ No____ Drink? Yes____ No____
		30. Have you ever used recreational drugs? Yes____ No____ Date of last use
		31. Women Only ...Are you pregnant? Yes____ No____ What month?
		32. Do you have any problems with your menstrual period?
		33. Do you use birth control pills?

Date _____ Signature _____

Reviewed with Patient by: _____ / _____

FOR OFFICE USE ONLY - DO NO WRITE BELOW THIS LINE

REFERRED BY:

X-RAY:

DATE RX:

			REFILLS:
____ Pen 250/500 mg.	NO. ____	Q6°	____
____ Cleocin 150 mg.	NO. ____	Q6°	____
____ TYL 3	NO. ____	Q3-4° PRN PAIN	____
____ Darvocet N – 100	NO. ____	Q4-6° PRN	____
____ Valium ____mg.	NO. ____	1 QHS	____
____ Motrin 800 mg.	NO. ____	Q8° PRN PAIN	____
____ Percocet	NO. ____	Q3-4° PRN	____
____ AHA Prophylaxis	NO. ____		____
____ Lorcet Plus	NO. ____	Q4-6° PRN	____
____ Tylox	NO. ____	Q4° PRN	____
____ Zithromax	NO. ____	UAD	____
____	NO. ____		____

ALVEO SUTURES

DATE DATE

DATE DATE

INFORMED CONSENT FOR SURGERY

This treatment can be done in the operating room of a local hospital if you desire. In this case the preanesthesia physical may be done by a physician on the staff of the hospital. You can expect, in addition to the fee we have quoted for oral surgical treatment, hospital charges plus the examining doctors and anesthesiologist's fees. You are responsible for determining extent of insurance coverage. An additional fee may be charged for hospital services.

This is to certify that I, the undersigned, consent to the performing of whatever oral surgical operation may be necessary or advisable. I agree to the use of a local anesthetic and/ or intra-venous sedation and/ or analgesia or general anesthesia. I have been given the choice of local anesthetic alone for the proposed oral surgery, if this is feasible.

I desire to have extraction or surgery as discussed and shown upon the examining chart and have had explained and understand the possible complications including but not limited to post operative infection, pain, swelling, limited jaw opening, bleeding, sinus involvement, loss or damage to other teeth and restorations, possible jaws fractures, root or tooth into the sinus, inhalation of foreign body possibly requiring surgical removal, damage to soft tissue, swelling, numbness and tingling, or pain of the lip, chin, gums, teeth, and tongue, lasting an indefinite period of time. I also understand that it may be advisable to leave a small piece of root in the jaw when its removal would likely cause nerve or other injury.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle, automobile or hazardous devices or work while taking such medications and/ or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device for at least twenty four hours after my release from surgery or until further recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office or hospital for my care. I agree not to drive myself home after surgery and will have a responsible adult drive me or accompany me home after my discharge from surgery, if I have had Intravenous Sedation or General Anesthesia.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

If additional surgery or treatment is indicated an additional fee will be added. We ask that if you wish to cancel a hospital surgical date that you give at least 72 hours notice of such cancellation.

I have read the above consent for operation, I have had my questions answered to my satisfaction and I understand it. It has been verbally explained to me that during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those discussed. I therefore authorize and request that the Doctor perform such procedures as are necessary and desirable in the exercise of professional judgement. The authority granted under this paragraph shall extend to the treatment of all conditions that required treatment and are not known at the time the original procedure is commenced.

I authorize the release of any medical information necessary to process an insurance claim and authorize assignment of any benefits directly to the doctor. Photos may be obtained for records and teaching purposes.

I also understand that if I am taking Birth Control pills and require antibiotics during the course of treatment that the effectiveness of the Birth Control pills may be reduced. I am hereby advised that use of additional birth control methods should be used for the cycle in which antibiotics are administered.

Signature_____ **Date** _____
(Parent or Guardian, if patient is a minor)

Signature_____ **Date** _____

Signature_____ **Date** _____

Signature_____ **Date** _____

Signature_____ **Date** _____

NOTES:

Surgery and sequelae verbally reviewed_____ / _____ / _____ **Date** _____