Welcome To Ramapo Oral & Maxillo-Facial Surgery, P.C.

Diplomates of the American Board of Oral & Maxillofacial Surgery

How did you hear of our practice? _____ Date _____

If this is Worker's Comp or No Fault related, please notify us immediately and provide pertinent information.

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Date of Birth _____ Age _____ Soc. Sec. # _____

Street _____ City _____ State _____ Zip _____

Home Tel. # (_____) _____ Cell (_____) _____

Email _____ Business Tel. # (_____) _____

Dentist _____ Medical Doctor _____ Referred By _____

Emergency Contact Name _____ Phone _____ Relationship _____

Pharmacy Name _____ Street _____ City _____ State _____

Who will be responsible for your account? *(If self, skip to next section)*

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____ Soc. Sec. # _____

Name _____ Date of Birth _____ Home Tel. # (____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Tel. # (____) _____

Inaccurate or incomplete insurance information will result in delayed payment to you from your insurance company.

PRIMARY ***DENTAL*** INSURANCE COMPANY

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Policy Holder _____

Date of Birth _____ Relation _____

I.D. # _____

Group # _____

S.S. # _____

PRIMARY ***MEDICAL*** INSURANCE COMPANY

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Policy Holder _____

Date of Birth _____ Relation _____

I.D. # _____

Group # _____

S.S. # _____

SECONDARY ***DENTAL*** INSURANCE COMPANY

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Policy Holder _____

Date of Birth _____ Relation _____

I.D. # _____

Group # _____

S.S. # _____

SECONDARY ***MEDICAL*** INSURANCE COMPANY

Ins. Co. Name _____

Address _____

_____ Tel. # (____) _____

Policy Holder _____

Date of Birth _____ Relation _____

I.D. # _____

Group # _____

S.S. # _____

STOP! DETACH TOP SHEET ONLY AND BRING TO FRONT DESK BEFORE PROCEEDING

Health History

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions.

Pertinent Medical Issues: _____

	YES	NO	
1. Are you in good health?	❑	❑	**Height** _____ **Weight** _____
2. Have there been any changes in your general health in the past year?	❑	❑	
If yes, explain _____			
3. Are you currently being treated by your physician for any medical conditions?	❑	❑	Date of last visit: _____
If yes, what are you being treated for _____			
4. Have you had any medical problems, operations or hospitalizations in the past 5 years?	❑	❑	
If yes, explain _____			
5. Do you have unhealed injuries or inflamed areas, growths or sore spots in your mouth?	❑	❑	
If yes, explain _____			
6. Have you ever had a joint replacement (knee, hip, shoulder, elbow)?	❑	❑	
If yes, describe where and when it was placed _____			
7. Have you had a heart valve replacement or vascular graft?	❑	❑	
If yes, explain _____			

IF YOU ARE HAVING SURGERY TODAY, have you had anything to eat or drink in the last 6 hours? ❑ Yes ❑ No

IF YOU ARE HAVING SURGERY WITH INTRAVENOUS SEDATION **(IV SEDATION), YOU MAY NOT DRIVE YOURSELF HOME AFTER SURGERY.**

WHO IS DRIVING YOU HOME AFTER SURGERY _____

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO	NOTES
8	Rheumatic fever?			
9	Damaged heart valves / mitral valve prolaps			
10	Heart murmur?			
11	High blood pressure?			
12	Low blood pressure?			
13	Chest pain, angina?			
14	Heart attack(s)?			
15	Irregular heart beat?			
16	Cardiac pacemaker?			
17	Heart surgery?			
18	Bronchitis, chronic cough?			
19	Asthma?			
20	Hay fever / sinus problems?			
21	Snoring / sleep apnea?			
22	Difficulty breathing / other lung trouble?			
23	Tuberculosis?			
24	Emphysema / COPD?			
25	Do you smoke?			
26	Blood transfusion?			
27	Blood disorder such as anemia?			
28	Bruise easily?			
29	Bleeding tendency (abnormal bleed)?			
30	Jaundice, hepatitis or liver disease?			
31	Infectious mononucleosis?			
32	Gallbladder trouble?			
33	Fainting spells?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO	NOTES
34	Convulsions, epilepsy?			
35	Stroke?			
36	Thyroid trouble?			
37	Diabetes?			
38	Low blood sugar?			
39	Kidney trouble?			
40	Are you on dialysis?			
41	Swollen ankles, arthritis or joint diseases?			
42	Stomach ulcers?			
43	Contagious diseases?			
44	Sexually transmitted diseases?			
45	Problems with the immune system?			
46	Delay in healing?			
47	Malignancy/Cancer Therapy?			
48	Radiation / chemotherapy?			
49	Chronic fatigue / night sweats?			
50	A history of drug abuse?			
51	A history of alcohol abuse?			
52	Contact lenses?			
53	Eye disease / glaucoma?			
54	Anxiety / Depression / Other mental health problems?			
56	A removable dental appliance?			
57	Pain & clicking of jaws when eating?			
58	Malignant hyperthermia?			

MEDICATION

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:
Attach list if necessary.

ARE YOU NOW TAKING OR HAVE YOU TAKEN…

		YES	NO	NOTES
61	Any kind of medicine, drugs or pills?			
62	Blood Thinners (Coumadin, Plavix, Aspirin, Warfarin, Eliquis, Pradaxa, Xeralto)?			
63	Are you currently taking diet pills?			
64	Any natural product, herbal supplement or homeopathic remedy?			
65	Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva Prolia, Evista)?			
66	Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:			

ALLERGIES

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO…

		YES	NO	NOTES
68	Local anesthetic (numbing med.)?			
69	Penicillin?			
70	Other antibiotics			
71	Sulfa Drugs?			
72	Sodium pentothal, Valium, or other tranquilizers?			
73	Aspirin?			
74	Codeine or other narcotics?			
75	Other medications?			
76	Latex?			
77	Soy?			
78	Eggs / Yolk?			
79	Morphine?			
80	Please list any other allergies:			

WOMEN

WOMEN NOTE: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult physician / gynecologist for assistance regarding additional methods of birth control.*

		YES	NO	NOTES
81	Is there a possibility of pregnancy?			
82	Expected delivery date? ___/___/___			
83	Are you nursing?			
84	Are you taking birth control pills?			

Is there a FAMILY HISTORY of:

Cancer	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Anesthetic Problems	❑ Yes	❑ No

I certify that I have read and I 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.

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X _____ X _____

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF MINOR) *DATE*

FEES & PAYMENTS

Please remember you are responsible for all fees charged by this office. If you have any dental or medical insurance, we will be glad to complete and submit the proper forms for you, BUT you are responsible to provide accurate and complete insurance information on the front page of this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all late payment fees, collection costs, attorneys fees, and court costs.

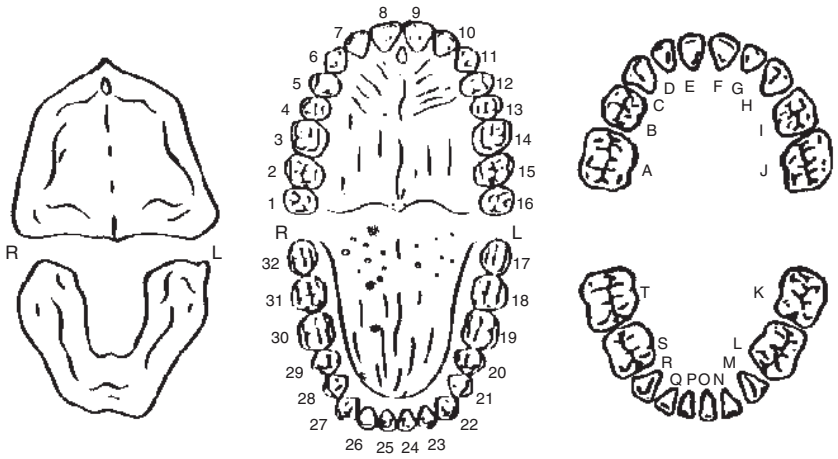
This signature on file is my authorization for the release of information necessary to process my claim. If I do not pay my account in full today, I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____

PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF MINOR) *DATE*

Progress Notes

PATIENT - DO NOT WRITE ON THIS PAGE



DATE	TOOTH	ANESTHESIA	TREATMENT

Patient's Last Name

First name

Middle initial