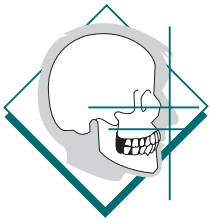

Welcome to
Oral & Facial Surgery Associates, Inc.

Patient: (Mr., Mrs., Ms., Dr.) First Name_____M.I._____ Last Name _____Nickname_____
Sex: ❑ Male ❑ Female Date of Birth _____ Age _____ Soc. Sec. # _____
Street _____ City _____ State _____ Zip _____
Home # (_____) _____ Business # (_____) _____ Ext. _____ Cell # (_____) _____
Dentist _____ Medical Doctor _____ Referred By _____
Employer _____ Pharmacy _____ Tel # (_____) _____
Have you ever been a patient of our practice? ❑ Yes ❑ No

Who will be responsible for your account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____
(If self, skip to next paragraph)
Name _____ Soc. Sec. # _____ Home Tel. # (_____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ Tel # (_____) _____

Spouse or other guarantor information (if different from above)
Name _____ Soc. Sec. # _____ Home Tel. # (_____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ Tel # (_____) _____

INSURANCE INFORMATION

PATIENT: Student: Full Time ❑ Part Time ❑ Not ❑ School Name/Address _____

PRIMARY DENTAL INSURANCE

Employer _____
Bus.Address_____
Bus.Tel#(_____)_____Plan_____
Ins.Co.Name_____
Address _____
_____Phone(____)_____
Group#_____**GroupName**_____
Insured Party_____Relation_____
Sex: ❑ Male ❑ Female Date of Birth _____
Street _____
City,State,Zip_____
Phone (_____) _____S.S.#_____
I.D.# _____

PRIMARY MEDICAL INSURANCE

Employer _____
Bus.Address_____
Bus.Tel#(_____)_____Plan_____
Ins.Co.Name_____
Address _____
_____Phone(____)_____
Group#_____**GroupName**_____
Insured Party_____Relation_____
Sex: ❑ Male ❑ Female Date of Birth _____
Street _____
City,State,Zip_____
Phone (_____) _____S.S.#_____
I.D.# _____

SECONDARY DENTAL INSURANCE

Employer _____
Bus.Address_____
Bus.Tel#(_____)_____Plan_____
Ins.Co.Name_____
Address _____
_____Phone(____)_____
Group#_____**GroupName**_____
Insured Party_____Relation_____
Sex: ❑ Male ❑ Female Date of Birth _____
Street _____
City,State,Zip_____
Phone (_____) _____S.S.#_____
I.D.# _____

SECONDARY MEDICAL INSURANCE

Employer _____
Bus.Address_____
Bus.Tel#(_____)_____Plan_____
Ins.Co.Name_____
Address _____
_____Phone(____)_____
Group#_____**GroupName**_____
Insured Party_____Relation_____
Sex: ❑ Male ❑ Female Date of Birth _____
Street _____
City,State,Zip_____
Phone (_____) _____S.S.#_____
I.D.# _____

I understand and agree that I **and** the Responsible Person signing below are responsible for payment of my bills. I authorize OFSA to submit claims to my health insurance plan(s). I assign the benefits of such insurance to OFSA and authorize payment of claims directly to OFSA. I understand and agree that I am responsible for all coinsurance, deductibles and non-covered services.

I consent to the use or disclosure of my protected health information and any other information about me for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. This includes disclosure of information to other health care providers referred or consulted for my care, to health insurance plans and to others engaged in health care operations.

I understand the information contained in these forms or otherwise given by me to OFSA will be used in submitting claims for payment and I certify that such information is correct. I authorize a copy of this form to be used in place of the original, and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying OFSA of any pre-certifications or referrals required by my health plans. I also understand that it will be **my responsibility** not that of OFSA, to confirm any contractual network affiliation with my insurance company.

_____

Patient/Legal Representative Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice for Oral and Facial Surgery Associates, Inc.

I, _____(print name) have been presented a copy of the Notice of Privacy Practices for Oral and Facial Surgery Associates, Inc. detailing how my health information may be used and disclosed under federal and state laws.

_____

Patient/Legal Representative Signature Date

1. May we discuss your healthcare with someone other that yourself? Yes/No
   If yes, whom may we discuss it with: _____?
   Relationship to patient: Spouse/ Parent/ Grandparent /Daughter /Son/Friend/Other: _____

2. May we leave test results or other treatment related information on your answering machine if you are not available? Yes/No

Name _____

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. Your answers are for our records only and will be considered confidential.

Reason for today's office visit:

Are you in good health? Height Weight
Have there been any changes in your general health in the past year?
Are you under the care of a physician? Date of last visit
If so, for what are you being treated?
Have you had any illness, operation or been hospitalized in the past five years?

Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth If so, describe where
Do you have a prosthetic joint/implant? If so, describe where
Have you had a heart valve replacement or vascular graft?

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
Rheumatic fever?				Stroke?			
Damaged heart valves/ mitral valve prolapse?				Thyroid trouble?			
Heart murmur?				Diabetes?			
High blood pressure?				Low blood sugar?			
Low blood pressure?				Kidney trouble?			
Chest pain, angina?				Are you on dialysis?			
Heart attack(s)?				Swollen ankles, arthritis or joint disease?			
Irregular heart beat?				Stomach ulcers?			
Cardiac pacemaker?				Contagious disease?			
Heart surgery?				Sexually transmitted disease?			
Bronchitis, chronic cough?				Problems with the immune system?			
Asthma?				Delay in healing?			
Hay fever / sinus problems?				A tumor or growth?			
Tuberculosis?				X-ray treatment/chemotheraphy?			
Emphysema?				Chronic fatigue/night sweats?			
Diffcult breathing/other lung trouble?				Are you on a diet?			
Do you smoke?				A history of drug abuse?			
Blood transfusion?				A history of alcohol abuse?			
Blood disorder such as anemia?				Contact lenses?			
Bruise easily?				Eye disease/glaucoma?			
Bleeding tendency (abnormal bleed)?				Mental health problems?			
Jaundice, hepatitis or liver disease?				Cancer ?			
Infectious mononucleosis?				A removable dental appliance?			
Gallbladder trouble?				Pain & clicking of jaws when eating?			
Fainting spells?				Malignant hyperthermia?			
Convulsions, epilepsy?							

MEDICATION

ARE YOU NOW TAKING...	Yes	No	Notes		Yes	No	Notes
Any kind of medicine, drugs, or pills?				Any kind of medicine for Osteoporosis?			
Anticoagulants? (Blood Thinner)				Have you ever taken diet pills?			
Tranquilizers?				Please list any other medications you are taking:			
Cortisone?							

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Yes	No	Notes
Local anesthetics?				Codeine or other narcotics?			
Penicillin?				Other medications?			
Other antibotics?				Latex?			
Sodium pentothal, valium, or other tranquilizers?				Please list any allergies other than drug allergies:			
Aspirin?							

WOMEN

Are you pregnant?				Are you nursing?			
Estimated delivery date? ___/___/__				Are you taking birth control pills?			
Date of last menstrual period ___/___/__							

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

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? ❑ Yes ❑ No

Do you wish to speak to the doctor privately about anything? ❑ Yes ❑ No

Is there a **family history** of **Cancer** ❑ Yes ❑ No **Diabetes** ❑ Yes ❑ No **Heart Disease** ❑ Yes ❑ No **Anesthetic Problems** ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT: Name: _____ Tel # H (_____) _____ W (_____) _____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: ❑ Yes ❑ No Work Related: ❑ Yes ❑ No Other: ❑ Yes ❑ No

Date of Injury _____ Insurance Co. handling this claim _____ Claim # _____

Name of Attorney / Adjustor _____ Tel # (_____) _____

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 ommissions that I have made in the completion of this form.

Signature of patient: **(Parent or Guardian if minor)** **Reviewed by:** **Date:**

PATIENT: DO NOT WRITE BELOW THIS LINE!

DATE	NOTES