Excellence in Oral & Maxillofacial Surgery, LLC

Welcome to our office! We appreciate you taking the time to complete the following forms.
Please complete every line item. Thank you!

PERSONAL INFORMATION

Dr. Mr. Mrs. Ms. Male Female Nickname: _____

Patient Name: _____ DOB: _____/_____/_____

Mailing Address: _____
Street City State Zip Code

Patient Social Security #:_____Email:_____

Person Responsible for Account: _____ Self Spouse Parent Guardian Other

DOB: ____/____/_____Social Security #:_____ Employer: _____

Billing Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Emergency Contact Information: Name: _____ Phone #:_____

Whom may we thank for referring you to our office? _____

Has Dr. Vetter ever treated a family member or friend: Y N Name: _____

Dentist: _____ Orthodontist: _____

INSURANCE INFORMATION

DENTAL Insurance

Insurance Co. Name: _____
Insurance Address: _____
_____
Group #:_____ Subscriber ID #:_____
Insurance Policy Holder: _____
Employer (for group plans):_____
DOB: _____/_____/_____ SSN: _____-_____-____

MEDICAL Insurance

Insurance Co. Name: _____
Insurance Address: _____
_____
Group #:_____ Subscriber ID #:_____
Insurance Policy Holder: _____
Employer (for group plans):_____
DOB: _____/_____/_____ SSN: _____-_____-_____

I hereby certify that the above information is true and correct to the best of my knowledge. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits from unless otherwise stated payable to me.

Responsible Party Signature: _____ Date: _____/_____/_____

UPDATE: Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

Excellence in Oral & Maxillofacial Surgery, LLC

PATIENT HEALTH HISTORY

(Your responses are for our records only and will be strictly confidential)

Name: _____ Ht: _____ Wt: _____ Age: _____ DOB: _____/_____/_____

Are you currently under a physician's care? Y N If so, please explain: _____ Physician: _____

ALLERGIES:	Y	N		Y	N	
	__	__	Local Anesthetic	__	__	Penicillin's
	__	__	General Anesthetic	__	__	Sulfa Drugs
	__	__	Aspirin	__	__	Soy, Eggs, Milk, Peanuts
	__	__	Latex	__	__	Other: Please list_____
	__	__	Codeine/Narcotics	__	__	_____

MEDICATIONS: _____

SURGERIES or HOSPITILIZATIONS_____

PLEASE INDICATE YES OR NO FOR EACH OF THE FOLLOWING

Y	N		Y	N	
__	__	High Blood Pressure	__	__	Tumor or Growth
__	__	Chest Pain or Angina	__	__	Chemotherapy or Radiation
__	__	Heart Disease, Heart Attack	__	__	Seizures, Epilepsy
__	__	Heart Murmur, Mitral Valve Prolapse	__	__	Osteoporosis
__	__	Shortness of Breath	__	__	Bisphosphonate Medications
__	__	Stroke	__	__	Mental Health Problems
__	__	Cardiac Pace Maker and/or Defibrillator	__	__	Alcohol and/or Drug Abuse
__	__	Sinusitis, Seasonal Allergies	__	__	Arthritis
__	__	Asthma	__	__	Jaw Joint Problems
__	__	Emphysema	__	__	Diabetes
__	__	Tuberculosis	__	__	Thyroid Problems
__	__	Do You Smoke? # of packs per day_____	__	__	Anemia
__	__	Smokeless Tobacco? Years of Use_____	__	__	Sickle Cell Trait/Disease
__	__	Stomach Ulcers	__	__	Bruise Easily
__	__	Kidney Problems	__	__	Abnormal/Prolonged Bleeding (Disorder)
__	__	Joint Problems/Replacements	__	__	Liver Disease or Hepatitis
__	__	Do you have any problems chewing or eating?			
__	__	Do you have any breathing problems?			
__	__	Do you snore, or have you been told you do?			
__	__	Is there anything else we should know? Please explain.			
__	__	Would you like to discuss anything in private?			
		If yes, with:Surgical Asst ___Doctor ___Practice Manager			

Female Patients

Hormone Replacement Therapy Y___ N___
Birth Control Pill/Patch/Injection/Other Y___ N___
Pregnant? Y___ N___ Nursing? Y___ N___

*I hereby certify that the above information regarding the medical history of _____ is complete, true, and correct and may be relied upon for all purposes by **Excellence in Oral and Maxillofacial Surgery, LLC,** their assistants, associates, and any other persons treating or assisting in the treatment of the patient.*

Signature: _____ Date: _____/_____/_____

Provider/Witness: _____ Date: _____/_____/_____

UPDATE: Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____