Welcome to our office. So that we may assist you in filing your dental/health insurance, please provide us with the information requested below. PLEASE PRINT CLEARLY. All information is kept confidential.

Patient Name________________ Age _____ Sex _____ Date of Birth ________

Home Address ________________ City ________ State ____ Zip ______

Home Phone (____) __________ Social Security # ______________

Employer's Name ________________ Business Phone (____) __________

Business Address ________________ City ________ State ____ Zip ______

Student: Full Time ____ Part Time ____ Name of School ________________ State ______

Family members who have been patients here __________ Referring Doctor __________

Reason for Visit ________________________________

Person financially responsible for this bill ____________________

Dental Insurance ________________ Policy ID # __________ Group ______

Medical Insurance ________________ Policy ID # __________ Group ______

IF THE PATIENT IS NOT THE SUBSCRIBER OF THE INSURANCE PLANS, THIS BOX MUST BE COMPLETED

Primary Subscriber ________________ Relationship to Patient __________

Home Address ________________ City ________ State ____ Zip ______

Home Phone (____) __________ Employer __________ Business Phone (____) __________

Business Address ________________ City ________ State ____ Zip ______

Social Security # __________ Date of Birth __________

Patients Must Sign Below:

Full Payment, Co-Payment and Deductibles are due at the time of service. Any balance over 90 days old is subject to finance charges of 1.00% monthly, 12% annually. You will be responsible for all collection costs, attorney fees and court costs.

Signature of Patient or Responsible Party ____________________ Date ________

PLEASE COMPLETE HEALTH HISTORY FORM ON REVERSE SIDE

HEALTH HISTORY

Patient's Name ______________ Date of Birth ______________ Date ______________

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? .... Y N
2. Has there been any change in your general health in the past year? .... Y N
3. Date of last physical exam ______________
   Physician's Name ______________
   Address ______________
4. Are you now under a physician's care for a particular problem? .... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: .... Y N
   ____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ...... Y N
   - B. Congenital Heart Disease? .... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? .... Y N
   - H. Kidney Disease? .... Y N
   - I. Diabetes? .... Y N
   - J. Thyroid Disease (Goiter)? .... Y N
   - K. Arthritis? .... Y N
   - L. Stomach Ulcers or Colitis? .... Y N
   - M. Glaucoma? .... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .... Y N
   - O. Radiation (X-ray) treatment for Cancer? .... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? .... Y N
   - Q. Sinus or Nasal problems? .... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? .... Y N
   - B. Anticoagulants (Blood Thinners)? .... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.. Y N
   - D. High Blood Pressure medications? .... Y N
   - E. Steroids (Cortisone, etc.)? .... Y N
   - F. Tranquilizers .... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?. Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax ,Actonel or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers) ? .... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: ______________
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .... Y N
   - B. Penicillin or other antibiotics? .... Y N
   - C. Sedatives, Barbiturates? .... Y N
   - D. Aspirin or Ibuprofen? .... Y N
   - E. Codeine or other pain killers? .... Y N
   - F. Latex or Rubber Products? .... Y N
   - G. Other allergies or reactions? Please, list .... Y N
   ____
10. Do you smoke or chew Tobacco? .... Y N
    How much per day? _________
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? .... Y N
12. Have you had any serious problems associated with any previous dental treatment? .... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? .... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .... Y N
15. Do you wish to talk to the doctor privately about anything? .... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? .... Y N
    - B. Are you nursing? .... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date ______________ Signature of Person Completing Health History ______________ Doctor's Initials ______________

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Medical Update: I have ready my Health History dated ______________ and confirm that it adequately states past and present conditions.

Date ______________ Exceptions or changes ______________ Patient's Signature ______________ Doctor's Initials ______________

Acknowledgement of Patient Responsibility

Fees for treatment are due at the time of service. I understand that my insurance will be billed as a courtesy, and it is my responsibility to know and understand the exclusions and limitations of my dental insurance policy. Should my insurance change, I understand that it is my responsibility to inform Oral Surgery Specialists of Austin with this information.

I understand that fees given are only an estimate and agree to pay all fees (co-pays and deductibles) in full, as well as any portion not covered by my insurance company for ANY reason.

____

Printed Patient Name

____

Signature (parent or legal guardian signature if patient is a minor)

____

Date

Patient Disclosure Instructions

In general, the **HIPAA** privacy rule gives individuals the right to request at restriction on uses and disclosures of their protected health information (**PHI**). The individual is also provided the right to request a confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone:____________
( ) Okay to leave detailed message
( ) Leave message with call-back number only

Written Communication (email):___________________
( ) Okay to email
( ) Okay to text

I allow you to give my clinical information to or answer questions from (check all that apply, please list names):

( ) Spouse
( ) Parent
( ) Child
( ) Other (specify): _____________________________

____
Printed Patient Name

____
Signature (parent or legal guardian signature if patient is a minor)

____
Date