

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Home Address: \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_ Email address: \_\_\_\_\_  
 \_\_\_\_\_ ( optional )

Social Security: \_\_\_\_\_ Driver's License: \_\_\_\_\_  Single  Married Spouse Name: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Are you a previous patient of CJS?  Yes or  No

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialist name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of your last dental examination: \_\_\_\_\_

Who may we thank for referring you to CJS? \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ (optional)

Why are you here to see us today? \_\_\_\_\_

*The following medical information is for your general welfare, whether you are here for diagnostic consultation, a simple extraction, or a major oral surgical procedure. Your general health may have significant affect on your current condition and on the outcome of any proposed treatment. For the sake of your overall health and safety, please answer all questions.*

**Have you ever had?**

Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Disease / Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis
Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Surgery / Heart Valve	Yes <input type="checkbox"/> No <input type="checkbox"/> Kidney Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Murmur / Abnormal Heart Sound	Yes <input type="checkbox"/> No <input type="checkbox"/> Ulcers
Yes <input type="checkbox"/> No <input type="checkbox"/> Irregular Heart Beat	Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid Disease
Yes <input type="checkbox"/> No <input type="checkbox"/> Cerebrovascular Disease ( Stroke/ TIA)	Yes <input type="checkbox"/> No <input type="checkbox"/> Glaucoma
Yes <input type="checkbox"/> No <input type="checkbox"/> Rheumatic Fever/ Rheumatic Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Tumor / Cancer
Yes <input type="checkbox"/> No <input type="checkbox"/> High or Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/> Radiation Treatment
Yes <input type="checkbox"/> No <input type="checkbox"/> Pain in Chest	Yes <input type="checkbox"/> No <input type="checkbox"/> Chemotherapy
Yes <input type="checkbox"/> No <input type="checkbox"/> Pain in Arms	Yes <input type="checkbox"/> No <input type="checkbox"/> Immune System Compromise
Yes <input type="checkbox"/> No <input type="checkbox"/> Swelling of Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent Infections
Yes <input type="checkbox"/> No <input type="checkbox"/> Lung Trouble / TB / + PPD	Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety / Depression / Psychiatric Illness
Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma / Bronchitis/ Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/> Treatment by a Psychiatrist / Psychologist
Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/> Surgeries / Dates:
Yes <input type="checkbox"/> No <input type="checkbox"/> Sinus Problems	
Yes <input type="checkbox"/> No <input type="checkbox"/> Snoring / Sleep Apnea	
Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes	
Yes <input type="checkbox"/> No <input type="checkbox"/> Bleeding Problems / Bleed or Bruise Easily	<b>Have you ever had allergies to:</b>
Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Transfusion	Yes <input type="checkbox"/> No <input type="checkbox"/> Penicillin
Yes <input type="checkbox"/> No <input type="checkbox"/> Told that you cannot donate blood	Yes <input type="checkbox"/> No <input type="checkbox"/> Aspirin
Yes <input type="checkbox"/> No <input type="checkbox"/> Jaundice or Liver Disease / Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/> Codeine
Yes <input type="checkbox"/> No <input type="checkbox"/> Anemia / Sickle Cell Disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Demerol
Yes <input type="checkbox"/> No <input type="checkbox"/> Convulsions / Seizures / Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/> Anesthetics (such as Novocaine, etc.)
Yes <input type="checkbox"/> No <input type="checkbox"/> Dizziness / Fainting	Yes <input type="checkbox"/> No <input type="checkbox"/> Iodine
Yes <input type="checkbox"/> No <input type="checkbox"/> Prosthetic Joint Surgery (Artificial)	Yes <input type="checkbox"/> No <input type="checkbox"/> Any Foods
Yes <input type="checkbox"/> No <input type="checkbox"/> Painful Joints	Yes <input type="checkbox"/> No <input type="checkbox"/> Other Drugs:

# GENERAL HEALTH QUESTIONNAIRE

**FOR WOMEN ONLY:** Are you, or could you be, pregnant?  Yes  No

Are you taking birth control pills?  Yes  No

**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.

- Are you seeing a specialist now (cardiologist/hematologist, etc.)?  Yes  No

If yes, please explain: \_\_\_\_\_

- Are you now under the active care of a physician for any reason?  Yes  No

If yes, please explain: \_\_\_\_\_

- When was your last physical examination? \_\_\_\_\_ Was anything unusual or abnormal found?  Yes  No

If yes, please explain: \_\_\_\_\_

- Are there any other medical conditions which we should be aware of?  Yes  No

If yes, please explain: \_\_\_\_\_

- Do you or have you taken any medications, including prescription medications, diet pills, over-the counter medications, herbal or holistic remedies, vitamins or minerals:  Yes  No If yes, please list: \_\_\_\_\_

- If you have ever taken any diet pills, have you had a medical examination to insure that your heart valves were not affected?  Yes  No If yes, when?: \_\_\_\_\_

- Have you ever been advised not to take a medication?  Yes  No

- Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, or Zometa)?  Yes  No

If yes, when? \_\_\_\_\_

- Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? \_\_\_\_\_

- Do you have a cold or cough at this time?  Yes  No Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_

- Do you drink alcoholic beverages?  Yes  No If yes, how much? \_\_\_\_\_

- How much do you weigh? \_\_\_\_\_ Do you wear contact lenses?  Yes  No

- Have you had general anesthesia before?  Yes  No

- Have you or a member of your family ever had difficulty with or a bad reaction to general anesthesia?  Yes  No

If yes, please explain: \_\_\_\_\_

I CERTIFY THAT THE MEDICAL HISTORY I HAVE GIVEN ABOVE IS CORRECT:

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if minor)

DOCTOR'S REVIEW:

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

**MEDICAL HISTORY UPDATE** (To be filled out at follow-up appointment)

- Have there been any changes in your health since you last reviewed this form?  Yes  No

If yes, for what conditions? \_\_\_\_\_

- Are you taking any new medications?  Yes  No If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

# COASTAL JAW SURGERY OFFICE POLICIES

## CONSENT FOR EXAMINATION & X-RAYS/AUTHORIZATION FOR RELEASE

I authorize the Doctor 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 release of any information acquired in the course of my examination or treatment.

Date: \_\_\_\_\_ Signature of Authorized Person: \_\_\_\_\_

**FINANCIAL POLICY:** We will be sure to discuss our estimated fees prior to the beginning of your treatment.  
PAYMENT OF FEES IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

**SINCE OUR PROFESSION IS BASED ON AN APPOINTMENT SCHEDULE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS. UNLESS YOUR APPOINTMENT IS CANCELED AT LEAST 24-HOURS IN ADVANCE, A CHARGE OF \$30.00 WILL BE APPLIED TO YOUR ACCOUNT.**

**REGARDING INSURANCE:** We file insurance as a courtesy for our patients. We will accept assignment of insurance benefits for certain procedures. However, we do require co-payment to be paid at the time of service. Any remaining balance, or non-covered expense, is the responsibility of the insured/patient.

**INSURANCE INFORMATION: (Please give both your dental and medical insurance card(s) to the receptionist to copy).**

Do you have Medicare : Yes \_\_\_\_\_ No \_\_\_\_\_

**INSURED:**  Self  Spouse  Mother  Father  Other \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Home#: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Does your plan cover:  Dental  Medical  Both

Group No: \_\_\_\_\_ Group Name: \_\_\_\_\_

**RESPONSIBLE BILLING PARTY:** :  Self  Spouse  Mother  Father  Other \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Home#: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work# \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

I have read the FINANCIAL POLICY. I understand and agree to this FINANCIAL POLICY:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize COASTAL JAW SURGERY to furnish information to \_\_\_\_\_ Insurance Company concerning my care. I further hereby assign all payments for medical services rendered to me, or my dependents, by the above insurance company. I understand that I am fully responsible for any portion of those services not covered by my insurance benefits. **MEDICARE ASSIGNMENT OF BENEFITS AUTHORIZATION.** I authorize the release of any medical or other information necessary to process this claim. I request payment of government benefits to be provided to the party who accepts assignment. I also understand that I am responsible for 20% of the Medicare approved amount and the deductible.

Date: \_\_\_\_\_ Signature or Authorized Person: \_\_\_\_\_