GENERAL HEALTH SCREENING

Please circle “Yes” or “No” for each question.

Question		
Have you been experiencing ANY symptoms of Cold, Flu, or COVID? If yes, please describe:	Y	N
Have you been advised within the last three weeks to quarantine due to exposure of an individual that has tested positive for COVID-19?	Y	N
Are you currently waiting on the results of a COVID-19 test? If yes, when were you tested?	Y	N
Have you been diagnosed with COVID-19? If yes, when?	Y	N

Signature ______________________________ Date _____________

Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT INFORMATION

First Name ________________________ M.I. ________ Last Name ________________________

Nickname ________________ Dentist ________________ Referring Doctor ________________

Mailing address ________________________ City ________________ State ________ Zip __________

Cell Phone ________________________ Home Phone (if different) ________________________

Birth Date _______/_______/__________ Sex: M / F / Other Social Security number ________________________

Marital status: Married / Single / Widowed / Divorced Has a family member been a patient of our practice? Y / N

Employer / School ________________________ Fulltime / Part time Work Phone ________________________

Personal email ____

Emergency contact ________________________ Relationship ________________ Phone ________________

PERSON RESPONSIBLE FOR PAYMENT / MUST BE FILLED OUT BY PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OLD

☐ Self (if self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other ________________

First Name ________________ Last Name ________________ Nickname ________________

Mailing address ________________________ City ________________ State _______ Zip __________

Home Phone (   ) ________________ Cell Phone (   ) ________________

Birth Date _______/_______/__________ Sex: M / F / Unspecified Social Security number ________________

Marital Status ________________ Email ________________________________

PRIMARY INSURANCE – PLEASE PROVIDE CARD(S) AT FRONT DESK

Dental Insurance: ________________________

Member ID# ________________________

Group# ________________ EDI/Payer ID:________________

Claims mailing address: ________________________

____

Policy holder name: ________________________

Relationship to patient: ________________________

Birth date: _______/_______/__________

Policy holder's mailing address:________________________

____

Medical Insurance:________________________

Member ID# ________________________

Group# ________________ EDI/Payer ID:________________

Claims mailing address: ________________________

____

Policy holder name: ________________________

Relationship to patient: ________________________

Birth date: _______/_______/__________

Policy holder's mailing address:________________________

____

For patients 18 years old and over:

I authorize you to speak to: ________________________________ *Relationship:* ________________

I authorize you to speak to: ________________________________ *Relationship:* ________________

HEALTH HISTORY

Patient Name ____ Birth Date ____/____/____ Age _____ Today's Date ________________

Please complete the health history so that we may provide the best possible care; the doctor will discuss the history with you prior to beginning treatment.

GENERAL INFORMATION

Sex: M / F / Unspecified Height ____________________ Weight _____________________ Are you in good health? Y / N

Reason for today's office visit? ____

Are you now under a physician's care for a particular problem? If so, describe: ____

____

Physician name and telephone # ____ Date of last physical exam ___________________

Has there been any change in your general health in the past year? If so, describe: ____

____

Have you ever had any serious illness? If so, describe: ____

____

Have you ever been hospitalized or had any surgery or anesthesia? If so, describe: ____

____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Y / N

A) PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Can you take pills?
2. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
3. Do you grind or clench your teeth?
4. Have you had any serious problems associated with previous dental treatment?
5. Have you or an immediate family member had any problem associated with anesthesia?
6. Do you smoke or chew tobacco?
   How much? __________________
   For how long? ________________
7. Have you ever quit smoking? _____________
   How long ago? ___________
8. Is there any past history of alcohol or chemical dependency?
9. Is there any emotional or psychiatric illness that may affect the care we provide?
10. Do you wish to talk to the doctor privately about anything?

B) FOR FEMALE PATIENTS ONLY

1. Are you pregnant, or is there any chance you might be pregnant? __________________ How many weeks along? ________________
2. Are you nursing?_______________________

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. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

Williams Oral & Maxillofacial Surgery, Prof LLC.

C) DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High blood pressure?
3. Stroke?
4. Heart surgery? (bypass or stent)
5. Pacemaker?
6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy?
8. Seizures?
9. Brain Injury?
10. Fainting / dizziness?
11. Bleeding disorder / anemia?
12. Blood transfusion?
13. Bruise or bleed easily?
14. Liver disease? (jaundice, hepatitis)
15. Kidney disease?
16. Diabetes?
17. Thyroid disease?
18. Arthritis?
19. Stomach ulcers or acid reflux? (GERD)
20. Other GI disease?
21. Glaucoma?
22. Osteoporosis?
23. Joint replacements?
24. Cancer?
25. Radiation therapy?
26. Chemotherapy?
27. Sinus and/or nasal problems?
28. Seasonal allergies?
29. Snore?
30. Sleep apnea?
31. Fibromyalgia?
32. Psychiatric illness or mood disorder?
33. Disease or medication that has depressed your immune system?
34. Organ transplant?
35. Delay in healing?
36. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?

D) ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia (Novocain, etc.)?
2. Penicillin?
3. Other antibiotics?
4. Sedatives, barbiturates?
5. Aspirin?
6. Ibuprofen?
7. Codeine or other pain killers?
8. Latex or rubber products?
9. Chemicals or jewelry (rash or sensitivity)?
10. Food products? Soy? Eggs?
11. Have you ever been advised to **not** take a medication?
12. Other allergies or reactions? If so, please list:

____

____

E) ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners (Coumadin, Plavix, etc.)?
3. Aspirin?
4. Ibuprofen?
5. Steroids (cortisone, prednisone, etc.)?
6. Sleep Aids / Trainquilizers?
7. Antidepressants?
8. Narcotics?
9. Insulin or oral anti-diabetic drugs?
10. **Have you ever taken** bisphosphonates, antiangiogenic, antiresorptive bone density medications? (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia, Avastin, Sutent)
11. **Other Medications: (please provide list)**

____

____

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. To the best of my knowledge, the information given on these three pages is true and correct.

____

Patient / Legal Guardian Signature **Date**

Williams Oral & Maxillofacial Surgery, Prof LLC

PATIENT NAME: ____

Financial Responsibility

I understand and agree to the following:

- **I am responsible for any and all charges on this account.**
- **Full payment is due on the day of service, unless other arrangements were made before today.**
- **Insurance**:
    - **Any payment made by me on the day of my appointment is only a down-payment.** My insurance payment may be significantly less than the remaining balance on my account. **I understand that I will be billed for any remaining balance on my account.**
    - **IV sedation/general anesthesia:** Insurance companies do not cover sedation for simple, uncomplicated tooth extractions.
    - **ConeBeam CT scans:** Dr. Williams may require a CBCT scan for my treatment. These scans are often **not covered** by any insurance**. I understand I am responsible for this charge.**
    - **Bone Grafts:** Sometimes after a tooth is extracted, a bone graft is needed to preserve the site for a future implant. These are often not covered by dental insurance when done at the time of extraction. If Dr. Williams and I decide a bone graft is needed, I understand I may be responsible for the full amount.
    - **Medicare** does **not** cover tooth extractions or sedation for tooth extractions**. I understand that I am responsible for these charges.**
    - **I understand that I am responsible for any and all charges not covered by my insurance**. Balances after insurance must be paid off by six months unless other arrangements have been made.
    - I authorize direct payment to Williams Oral and Maxillofacial Surgery Prof LLC by my insurance company. A copy of this original may be used in place of the original.
- If no attempt is made to pay an account balance more than 60 days old, my account will be assessed a **late fee of $35.00 per month**, every month, until the account is paid in full. Alternatively, a collection agency may be utilized. **I understand it is my responsibility to inform this office of any change of address.**

Signature: ______________________________________ Date: ________________

Acknowledgement of Receipt of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date: ______________

Printed Name: __________________________________ (Please initial if you refuse to sign _________)