Welcome to Our Office

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Diplomates American Board Oral & Maxillofacial Surgery

Patient Information

Name _____ Sex____ Birth Date_____

Social Security # _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Emergency Contact _____ Phone No. ( ) _____

Who is your Dentist? _____ M.D.? _____

Please tell us who referred you? _____

Insurance Information

Who is the primary insurance holder? (please circle) Patient Father Mother Spouse

Name of primary Insurance holder: _____ **D.O.B.** _____

The Social Security number of the primary insurance holder is _____

Dental Insurance _____ **Group#**_____

Medical Insurance_____ **ID#**_____

Financial Agreement: I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have answered all the questions. I certify that this information is true to the best of my knowledge. In the event that this account goes into collection, I will be responsible for any collection fees incurred by me in the collection process.

For patients with Insurance: We will assist you with filing your insurance claims. Patients are responsible for any balance on their account not covered or paid for by their insurance. It is not our policy to contact insurance carriers to establish why they may have not paid or why they may have paid less than originally indicated since we are not part of your agreement with your insurance carrier.
An interest rate of 1.5% will be charged on all past due accounts. I have read, I understand, and I agree to the financial policy, and I am financially responsible for all treatment.

Signature of Responsible Person _____ Date _____

***Medical History Reviewed** _____

Medical History

Have you had anything to eat or drink in the last 8 hours? Y ____ N ____
Have you premedicated yourself with antibiotics today? Y ____ N ____
(For patients who have a heart murmur, history of rheumatic fever, or prosthetic joint)

Please mark Yes if you now or ever have had any of the following, otherwise, please mark No:

Y	N		Y	N	
____	____	**Rheumatic Fever or Heart Murmur**	____	____	**Hepatitis or Liver Disease**
____	____	**Heart Disease, Angina, or Chest Pains**	____	____	**Drug Abuse History**
____	____	**High Blood Pressure**	____	____	**Diabetes, (Sugar)**
____	____	**Stroke**	____	____	**Thyroid Disease**
____	____	**Lung Disease, Bronchitis or Asthma**	____	____	**Kidney Disease**
____	____	**Auto-immune disease, Lupus, Sarcoidosis**	____	____	**Seizures, Nervous disorders**
____	____	**Do you have a prosthetic joint?**	____	____	**HIV Positive (AIDS)**
____	____	**Sinus Problems**	____	____	**Cancer**
____	____	**TMJ Problems**	____	____	**Radiation Therapy**
____	____	**Are you pregnant? _____ weeks**	____	____	**Are you on blood thinners?**

____ ____ Are you **Allergic** to any medications or anesthetics? If yes, please list:_____

_____

What medications do you currently take? _____

_____

Special Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, and/or Other indicated Procedures

Patient: _____ You have both the right and obligation to make decisions concerning your health care. Our office can provide you with the necessary information and advice but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended.

1. I hereby authorize Dr. Rothman or Kim and/or any associates to treat the following condition(s) which has (have) been explained:

_____

2. The procedures planned for treatment of my condition have been explained to me. I understand them to be: _____

_____

3. I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate additional or different procedures then those above set forth. I, therefore, authorize Dr. Rothman or Kim and/or any assistants, to perform such surgical or other procedures as are in the exercise of his professional judgement necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to Dr. Rothman or Kim at the time the medical or surgical procedure is commenced.
4. I have been informed that there are significant risks such as nerve injuries to nerves of the tongue, chin, lips, or teeth, excessive bleeding, need for secondary procedures, infection, or cardiac arrest...leading to death or disability which may be attendant to any procedure. I acknowledge that no warranty or guarantee has been made to me as in result or cure. I understand that as a complication of extractions, tooth roots may be left, and/or injury to other teeth or tissues may occur. Prolonged temporary or chronic pain can be expected with any surgical procedure.
5. I consent to the administration of anesthesia by Dr. Rothman/Kim. I understand that all anesthetics involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver, and kidney, and that in some cases may result in paralysis, cardiac arrest and /or brain death from both known and unknown causes. I understand that I am not to operate any vehicle or hazardous devices for at least twenty four hours or until recovered from the anesthetic.
6. Any tissues or parts surgically removed may be disposed of by Dr. Rothman or Kim in accordance with accustomed practice.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in and that I understand its contents.

Patient or Guardian _____ Date _____ Dr. _____ Witness_____