ADVANCED ORAL SPECIALTY GROUP

BOARD CERTIFIED SPECIALISTS IN PERIODONTICS AND IMPLANT DENTISTRY

— ALAN M MELTZER, D.M.D., M.Sc.D.-DIRECTOR —

Date__________________

First Name_________________________ M.I.____ Last Name__________________________ Date of Birth________________
Age_________ ___Male___Female ___Minor ___Single ___Married ___Divorced ___Widowed ___Separated
Home Address____ City_________________________ State____ Zip Code______
Home Phone___________________ Business Phone ______________ Cell Phone ______________ Phone _____________
Employer's Name & Address____
Occupation____ Social Security #_________________________________
Pharmacy Name & Phone ____

Responsible Party

Name of person responsible for this account_______________________________________ Relationship__________________
Address_____________________________ City____________________ State____ Zip Code________ Phone______________
Employer's Name & Address____ Work Phone_____________________
Social Security #__________________________ Driver's License #____________________ Date of Birth__________________
Is this person currently a patient in our office? ____Yes ____No

Insurance Information

This facility is not a provider of any insurance carrier. Insurance will be billed for you as a courtesy.

Primary Dental Insurance Company_________________________Group #____________Employer/cert. #_________________
Name of Insured____ Relationship to Patient______________________
Employer's Name & Address____ Work Phone______________________
Social Security #__________________________ Driver's License #____________________ Date of Birth _________________
Insurance Company Address_______________________________ City_____________________ State___ Zip Code________
Secondary Dental Insurance Company_______________________Group #____________Employer/cert. #_________________
Insurance Company Address_______________________________ City_____________________ State___ Zip Code________
Primary Medical Insurance Company________________________Group #____________Employer/cert. #________________
Insurance Company Address_______________________________ City_____________________ State___ Zip Code________

Authorization, Release, and Agreement to Pay for Services Rendered…

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental/Medical care to third party payors and/or other health practitioners.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent. I understand that this facility is not a provider of any insurance carrier. I understand that payment in full is due on the day of service.

X ____ ______________________________

Signature of Patient or Parent If Minor ***Date***

Medical History Questionnaire

There are many situations which can affect or be affected by the procedures or drugs used for oral surgery. Therefore, please fill out the following carefully and accurately. If you are unsure of your answer, please leave space blank and Dr. Meltzer will review with you at your visit.

Patient's Name____ Date___________________ Date of Birth____________
Physician's Name & Phone Number________________________________ Date of last medical exam____________________
Dentist's Name____ Referred to this office by_________________________

1. Have you ever been hospitalized? ____**Yes** ____**No** If yes, for what reason?_______________________________________
2. Are you allergic to or have you had reactions to:

	YES	NO		YES	NO
Local Anesthetics like Novocaine, _______	____	____	Aspirin, Motrin or Ibuprofen	____	____
Penicillin or other antibiotics____________	____	____	Iodine	____	____
Sulfa Drugs	____	____	Latex Gloves	____	____
Barbiturates, Sedatives or Sleeping Pills	____	____	Soy or Egg Products	____	____

Other (please list) ___________________

3. Have you or are you taking any of the following medications or injections:

	YES	NO		YES	NO
Aspirin	_____	____			
Heart Medication_______________	_____	____	Anticoagulants (blood thinners)	____	____
Steroids_______________________	_____	____	Antibiotics_____________________	____	____
Narcotics______________________	_____	____	Diabetes Medication_____________	____	____
Recreational Drugs (Marijuana, etc.)	_____	____	Tranquilizers or sleeping pills______	____	____
Chemotherapy Medication________	_____	____	Phen Fen (Redux)_______________	____	____
Bisphosphinates (Fosamax, Boniva, etc.)	_____	____			

Other (please list) ____

4. Do you have or have you ever had any of the following:

	YES	NO		YES	NO
Rheumatic Heart Disease	____	____	Kidney Trouble	____	____
Scarlet Fever	____	____	Tuberculosis	____	____
Mitral Valve Prolapse or Heart Murmur	____	____	Persistent Cough	____	____
Heart Trouble, Heart Attack or Angina	____	____	Epilepsy or Seizures	____	____
Chest Pain	____	____	Anemia	____	____
Shortness of Breath	____	____	Glaucoma	____	____
Pacemaker	____	____	Nervousness	____	____
Heart Surgery	____	____	Tonsillitis	____	____
High or Low Blood pressure	____	____	Tumors	____	____
Congenital Heart Problems	____	____	Mental Health Care	____	____
Swelling of Feet, Ankles, Hands	____	____	Back Problems	____	____
Hepatitis, Jaundice or Liver Disease	____	____	Chemical Dependency	____	____
Stroke	____	____	Cortisone Treatment	____	____
Sinus Trouble	____	____	Cold Sores or Fever Blisters	____	____
Lung or Breathing Problems	____	____	Hypoglycemia	____	____
Asthma or Hay Fever	____	____	Eating Disorders	____	____
Hives or Skin Rash	____	____	Chemotherapy	____	____

	YES	NO
Fainting or Dizzy Spells	____	____
Diabetes	____	____
AIDS or HIV Infection	____	____
Thyroid Problems	____	____
Allergies	____	____
Arthritis or Rheumatism	____	____
Joint Replacement	____	____
Rheumatic Fever	____	____
Stomach Ulcer	____	____
Sexually Transmitted Disease	____	____

Applies to Women Only

	YES	NO
Are you nursing?	____	____
Are you pregnant?	____	____
Are you taking Birth Control Pills?	____	____

5. Do you smoke? ____Yes ____No, how frequently_____
6. Do you wear contact lenses? ____Yes ____No
7. Do you consume alcohol? ____Yes _____No, how frequently______
8. Have you been told that you are required to take premedication (antibiotics) prior to dental visits? ____Yes _____No

I herby certify that all of the above information is true and correct.

X ____ ____________________

Signature of Patient or Parent If Minor ***Date***

X ____ ____________________

Print Name ***Date***