UNION SQUARE
Oral Surgery & Dental Implant Center

General Patient Information

Date: _____

PATIENT INFORMATION:

Patient Full Name: _____

Preferred Nickname: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Home Ph#: _____

Cell Ph#: _____ Email: _____

Employer/School: _____

Employer/School Address: _____

Emergency Contact: _____ Contact Ph#: _____

Primary Dentist: _____ Dentist Ph#: _____

Primary Physician: _____ Physician Ph#: _____

Person Responsible for Bill (if other than patient): _____

Ph#: _____ Address: _____

INSURANCE INFORMATION:

*If you have your insurance card(s), please let us make a copy; some insurance plans require a copy of the card.
*If you have more than two insurance plans, please provide information on back of this form.

Primary Insurance: _____ Group #: _____

MEDICAL ☐ **DENTAL** ☐ **BOTH** ☐ Address: _____ Ph#: _____

Policyholder (if other than patient): _____ Date of Birth: _____

SSN: _____ Sex: _____

Relationship to Patient: _____ Policyholder Ph#: _____

Policyholder Address: _____

Secondary Insurance: _____ Group #: _____

MEDICAL ☐ **DENTAL** ☐ **BOTH** ☐ Address: _____ Ph#: _____

Policyholder (if other than patient): _____ Date of Birth: _____

SSN: _____ Sex: _____

Relationship to Patient: _____ Policyholder Ph#: _____

Policyholder Address: _____

FEES AND PAYMENTS:

We make every effort to keep down the cost of your oral surgical care. Unless other arrangements have been made, you are responsible for paying for charges at each visit. If you have insurance, we will submit the proper forms. Please remember that insurance is considered a method to reimburse the patient for fees paid to the doctor and is not a substitute for payment. Some insurance plans pay fixed allowances and others pay a percentage of the charges. **It is your responsibility to pay any deductibles, co-insurance, or any other balance not paid for by your insurance.** The signature below is my authorization for the release of information needed to process my insurance claim. I hereby authorize and request payment of insurance benefits otherwise payable to me be made directly to this doctor.

Patient Signature: _____ Date: _____
(Parent or Guardian if Minor)

PLEASE BRING THIS SHEET TO FRONT DESK BEFORE COMPLETING MEDICAL HISTORY FORM

UNION SQUARE
Oral Surgery & Dental Implant Center

Medical History

Name: _____

Height: _____ **Weight:** _____ **Age:** _____

- Date of last physical exam: _____
- Are you now under the care of a physician? ..... ☐ Yes ☐ No
  If yes, for what condition?: _____
- Have you had trouble with previous medical, dental, or surgical treatments? ..... ☐ Yes ☐ No
  If yes, explain?: _____
- Have you experienced abnormal bleeding with previous surgeries, extractions, or trauma? .... ☐ Yes ☐ No
  If yes, explain?: _____
- Have you had any serious illness, operation, or hospitalization (in the past 5 years)? ..... ☐ Yes ☐ No
  If yes, please explain: _____
- Do you bruise easily? ..... ☐ Yes ☐ No
- Have you ever required a blood transfusion? ..... ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had surgery or radiation for a tumor, cancer, or other head/neck condition? ..... ☐ Yes ☐ No
  If yes, please explain: _____
- Have you taken the diet pills Fen-Phen, Pondimin, or Redux? ..... ☐ Yes ☐ No
  If yes, have you had a medical exam to ensure your heart valves were not affected? ..... ☐ Yes ☐ No
- Do you wear contact lenses? ..... ☐ Yes ☐ No
- Are you allergic to, or have you reacted to, any of the following?
  - ☐ Local Anesthesia (Procaine, Novocaine, or Others)
  - ☐ Penicillin, Amoxicillin, Cephalosphorins, Sulfa, or Others
  - ☐ Aspirin or Ibuprofen
  - ☐ Latex Gloves
  - ☐ Codeine or Other Narcotics
  - ☐ Nitrous Oxide (Laughing Gas)
  - ☐ Other Allergy
    Please List: _____
- Do you have, or have you had, any of the following diseases or problems?
  - ☐ Rheumatic Fever or Rheumatic Heart Disease
  - ☐ Cardiovascular Disease (Heart Trouble)
  - ☐ Heart Attack, Angina, Chest Pain, or Stroke
  - ☐ High Blood Pressure
  - ☐ Heart Murmur
  - ☐ Shortness of Breath
  - ☐ Asthma or Emphysema
  - ☐ Tuberculosis or any Lung Disease
  - ☐ Persistent Cough or Cough-up Blood
  - ☐ Autoimmune Disorder (HIV or AIDS)
  - ☐ Fainting Spells or Seizures
  - ☐ Diabetes
  - ☐ Hepatitis, Jaundice, or Liver Disease
  - ☐ Arthritis or Other Joint Problems
  - ☐ Stomach Ulcers
  - ☐ Kidney Trouble
  - ☐ Venereal Disease (Past or Present)
  - ☐ Blood Disorder (Hemophilia, Anemia, Other)
  - ☐ Other Condition Doctor Should Know
    If So, Describe: _____
- Are you taking any of the following medications?
  - ☐ HIV Medications
  - ☐ Antibiotics or Sulfa Drugs
  - ☐ Anticoagulants (Blood Thinners)
  - ☐ High Blood Pressure Medication
  - ☐ Cortisone or Steroids, Including Prednisone
  - ☐ Tranquilizers
  - ☐ Aspirin
  - ☐ Insulin, Tolbutamide, Glyburide, or Similar Drugs
  - ☐ Digitalis, Nitroglycerin, or Drugs for Heart Trouble
  - ☐ Antihistamines
  - ☐ Oral Contraceptive or Hormonal Therapy
  - ☐ Other Medication
    Please List: _____

WOMEN ONLY

- Are you pregnant or have you missed a menstrual cycle? ..... ☐ Yes ☐ No
- Are you presently breastfeeding? ..... ☐ Yes ☐ No
- **WARNING**: Antibiotics may make birth control pills less effective. You should consult your doctor and consider alternate methods of birth control.
  I have read and understand this statement about birth control pills - PLEASE INITIAL: _____

- ***I have provided truthful information to assure I receive the best care possible.**
  Patient Signature: _____ Date: _____

FOR DOCTOR'S USE ONLY BP_____ P_____

Chief Complaints/Symptoms: _____

_____

_____

_____

AGE_____

PMH_____

MEDS_____

_____

ALL_____

TOB_____