NEW ENGLAND ORAL SURGERY

A. PATIENT INFORMATION

Name _____ Date of Birth _____

Street Address _____ Male ☐ Female ☐

Mailing Address _____ Soc. Sec. No. _____

City _____ State _____ Zip _____ Home Phone _____

Email _____

Marital Status S ☐ M ☐ W ☐ D ☐ Sep ☐ Cell Phone _____

Employer _____ Bus. Phone _____

Address _____

Name of Partner _____ Date of Birth _____ Soc. Sec. No. _____

Partner's Employer _____ Bus. Phone _____

Address _____

B. IF PATIENT IS MINOR OR STUDENT:

Patient's **College** _____ State _____

Father's Name _____ Date of Birth _____ Mother's Name _____ Date of Birth _____

Home Address _____ Home Address _____

_____ Phone _____ _____ Phone _____

Employer _____ Bus. Phone _____ Employer _____ Bus. Phone _____

C. INSURANCE INFORMATION:

Medical Insurance Carrier _____ Dental Insurance Carrier _____

Address _____ Address _____

Policy Holder _____ Policy Holder _____

Group No. _____ ID# _____ Group No. _____ ID# _____

Secondary Medical Insurance _____ Secondary Dental Insurance _____

Address _____ Address _____

Policy Holder _____ Policy Holder _____

Group No. _____ ID# _____ Group No. _____ ID# _____

Patient Name _____ **DOB** _____

All services rendered are charged to the patient. Patients are required to pay for services when rendered unless other arrangements have been made in advance. I authorize NEW ENGLAND ORAL SURGERY (NEOS) to furnish information to insurance carriers concerning my treatment and to verify employment or insurance coverage for myself, spouse and/or dependents. I assign NEOS all payments for services rendered to me or my dependents.

I understand that I am responsible for the payment of any amount not covered by insurance. Finance charges of 1 1/2% per month are assessed on accounts more than 90 days past due. If legal action is necessary to collect an unpaid balance for services rendered, I will pay all collection costs, attorney fees and court costs.

Printed Name _____ Relationship to Patient _____

Signature of Responsible Party _____ Date _____

Please Complete Reverse Side

Patient Medical History

Patient Name _____ **Date of Birth** _____

1. Do you have or have you ever been told you had the following? (CHECK YES OR NO AND CIRCLE APPROPRIATE CONDITION)

	Yes	No		Yes	No
A. Heart Disease or Murmur	☐	☐	M. Liver Disease or Hepatitis	☐	☐
B. Angina or Chest Pain	☐	☐	N. Epilepsy / Seizures	☐	☐
C. Rheumatic Fever	☐	☐	O. Glaucoma	☐	☐
D. High or Low Blood Pressure	☐	☐	P. Kidney Disease	☐	☐
E. Bleeding Disorder	☐	☐	Q. Sexually Transmitted Diseases	☐	☐
F. Anemia	☐	☐	R. Immune Problems or HIV	☐	☐
G. Diabetes	☐	☐	S. TMJ Dysfunction	☐	☐
H. Porphyria	☐	☐	T. Motion Sickness	☐	☐
I. Tuberculosis	☐	☐	U. Stomach Problems or Ulcers	☐	☐
J. Asthma, Bronchitis or Sinusitis	☐	☐	V. Depressions or Anxiety	☐	☐
K. Thyroid Problems	☐	☐	W. Osteoporosis / Osteopenia	☐	☐
L. Emphysema	☐	☐	X. Other_____		

2. Are you:

A. Currently under a doctor's care? (Dr.'s Name) _____ ☐ ☐

B. Pregnant, might be or trying to become pregnant? Due Date: _____ ☐ ☐

3. Are you allergic to:

C. Penicillin?	☐	☐
D. Other antibiotics?_____	☐	☐
E. Anesthetics or other drugs?_____	☐	☐
F. Latex Rubber?	☐	☐
G. Egg or Food Allergy?_____	☐	☐

4. Do you have:

A. Shortness of breath?	☐	☐
B. Swelling of the ankles?	☐	☐
C. A tendency to faint?	☐	☐
D. A chest cold now?	☐	☐

5. Do you:

E. Smoke? How much?_____	☐	☐
F. Chew tobacco?	☐	☐
G. Wear contacts?	☐	☐
H. Gag easily?	☐	☐

6. Have you ever been hospitalized or had surgery? For what reason?_____	☐	☐
7. Have you ever had complications from anesthesia? Explain _____	☐	☐
8. Have you ever had chemotherapy or radiation therapy?_____	☐	☐
9. Do you use alcohol or any recreational drugs?_____	☐	☐
10. Anything else we should know about?_____	☐	☐

11. Are you currently taking or in the last three months have you taken any of these medications?

A. Heart medications	☐	☐	G. Insulin	☐	☐
B. Blood pressure medications	☐	☐	H. Sedative/Tranquilizer/Anticonvulsants	☐	☐
C. Diuretic (water pill)	☐	☐	I. Diet Pills	☐	☐
D. Steroids	☐	☐	J. Antibiotics	☐	☐
E. Birth control pills	☐	☐	K. Herbal Medications	☐	☐
F. Anticoagulant (blood thinner)	☐	☐	L. Antidepressants/Antianxiety Medications	☐	☐
			M. Actonel, Boniva, Fosamax or Reclast	☐	☐

Please list all current medications and dose.

_____ _____

_____ _____

_____ _____

12a. Family Physician: _____ b. Family Dentist_____

13. Person to contact in case of an emergency:_____

Address: _____Phone: _____

14. Who referred you to our office?_____

15. What can we do to help you?_____

16. Is there anything you would like to discuss in private with the doctor? ☐ ☐

17. Reviewer's Comments:

Patient (Guardian) Signature _____ Reviewed by: _____ Date:_____