HEALTH HISTORY

Name ______________________________ Age ______________

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. ARE YOU IN GOOD HEALTH? .... Y N
2. ANY CHANGE IN YOUR HEALTH THE PAST YEAR? .... Y N
3. ARE YOU UNDER THE CARE OF A PHYSICIAN? .... Y N
   IF SO, PLEASE LIST HIS/HER NAME AND ADDRESS AND WHAT YOU ARE BEING TREATED FOR ______________
4. DO YOU HAVE, OR HAVE YOU HAD, A SERIOUS ILLNESS OR MEDICAL CONDITION? .... Y N
   IF SO WHAT? ______________
5. HAVE YOU HAD ANY INJURY, OPERATION, SURGERY OR HOSPITALIZATION? .... Y N
   IF SO, PLEASE DESCRIBE ______________
6. HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT, SURGERY, TRAUMA, OR ANESTHESIA (GENERAL OR LOCAL)? .... Y N
   IF SO, PLEASE DESCRIBE ______________
7. ARE YOU TAKING ANY DRUGS OR MEDICATIONS **PRESCRIBED BY A DOCTOR OR OVER THE COUNTER (INCLUDING BIRTH CONTROL PILLS, DIET PILLS, SLEEPING AIDS, ANTI-INFLAMMATORIES, ASPIRIN, SINUS/ALLERGY PREPARATIONS)** .... Y N
   IF SO, PLEASE LIST ______________
8. ARE YOU TAKING ANY NATURE PRODUCT, HERBAL SUPPLEMENT OR TEA, OR OTHER NATURE OR HOMEOPATHIC REMEDY? .... Y N
9. ARE YOU ALLERGIC TO ANY DRUGS, MEDICATIONS, LATEX OR RUBBER PRODUCTS OR FOODS .... Y N
   IF SO, PLEASE LIST ANY DRUGS, MEDICATIONS, FOODS OR OTHER SUBSTANCES THAT YOU ARE ALLERGIC TO: ______________
10. ARE YOU TAKING COUMADIN? .... Y N
11. ARE YOU TAKING OR HAVE YOU TAKEN ORAL BISPHOSPHONATES? .... Y N
    (FOSAMAX, DIDRONEL, BONIVA, OR ACTONEL)
12. HAVE YOU EVER RECEIVED IV BISPHOSPHONATES? .... Y N
    (OSTAC, DIDRONEL, BENEFOS, AREDIA, ZOMETA)
13. DO YOU HAVE A FAMILY HISTORY OF ANY ALLERGIC REACTION TO ANESTHESIA OR MUSCLE RELAXANTS? .... Y N

(PLEASE CIRCLE WHICH ONE)

14. DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE, DIABETES, HYPERTENSION, STROKE, OR BLEEDING DISORDER? .... Y N
15. DO YOU SMOKE, CHEW TOBACCO, OR DIP SNUFF? .... Y N
16. DO YOU DRINK ALCOHOL? .... Y N
17. DO YOU USE MARIJUANA OR OTHER "STREET" DRUGS? .... Y N
18. FOR WOMEN: ARE YOU PREGNANT OR NURSING A BABY? .... Y N
19. DO YOU OBJECT TO THE USE OF YOUR OR YOUR CHILD'S X-RAYS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC RECORDS BEING USED AS TEACHING MATERIAL IN LECTURES AND SCIENTIFIC JOURNALS? .... Y N

CONTINUE ON NEXT PAGE

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REVIEW OF SYSTEMS

20. CHECK IF YOU HAVE OR HAVE EVER HAD:

HEAD

- ☐ HEAD INJURY
- ☐ SEVERE OR CHRONIC HEADACHES

EYES

- ☐ VISION PROBLEMS
- ☐ GLAUCOMA

NOSE & SINUSES

- ☐ NOSEBLEEDS
- ☐ FREQUENT SINUS INFECTIONS

MOUTH & THROAT

- ☐ BLEEDING GUMS
- ☐ INFECTION
- ☐ HOARSENESS
- ☐ JAW JOINT PAIN, POPPING, LOCKING, DISLOCATION
- ☐ CLENCHING OR GRINDING TEETH
- ☐ LIMITED MOUTH OPENING

NECK

- ☐ LUMPS
- ☐ SWELLING
- ☐ PAIN OR STIFFNESS

RESPIRATORY (LUNGS)

- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ EMPHYSEMA
- ☐ COPD
- ☐ CHRONIC COUGH
- ☐ TUBERCULOSIS
- ☐ SHORTNESS OF BREATH

CARDIAC (HEART)

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ HEART ATTACK
- ☐ HEART FAILURE
- ☐ HEART SURGERY
- ☐ CORONARY ARTERY DISEASE (ANGINA)
- ☐ RHEUMATIC FEVER
- ☐ HEART MURMUR
- ☐ MITRAL VALVE PROLAPSE
- ☐ ARTIFICIAL HEART VALVE OR VALVE REPLACEMENT
- ☐ CONGENITAL HEART DISEASE (HEART BIRTH DEFECT)
- ☐ PACEMAKER
- ☐ INTERNALLY IMPLANTED DEFIBRILLATOR
- ☐ IRREGULAR OR RACING PULSE
- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ SWELLING OF HANDS, ANKLES, FEET

GASTROINTESTINAL

- ☐ STOMACH ULCERS
- ☐ BOWEL DISEASE
- ☐ COLITIS
- ☐ LIVER DISEASE
- ☐ JAUNDICE
- ☐ HEPATITIS
- ☐ CIRRHOSIS
- ☐ ACID REFLUX

GENITO URINARY

- ☐ SYPHILIS
- ☐ HERPES
- ☐ KIDNEY DISEASE
- ☐ GONORRHEA
- ☐ KIDNEY DIALYSIS

MUSCULO SKELETAL

- ☐ ARTHRITIS
- ☐ GOUT
- ☐ BACK PAIN
- ☐ TOTAL JOINT REPLACEMENT
- ☐ FIBROMYALGIA
- ☐ OSTEOPOROSIS

NEUROLOGIC

- ☐ BRAIN HEMORRHAGE OR STROKE
- ☐ SEIZURES, CONVULSIONS, OR EPILEPSY
- ☐ BLACK OUTS
- ☐ TREMORS
- ☐ TIA'S
- ☐ MENTALLY CHALLENGED

HEMATOLOGIC

- ☐ ANEMIA
- ☐ LEUKEMIA
- ☐ BLOOD DISORDER
- ☐ BLEEDING DISORDER (I.E. HEMOPHILIA)

ENDOCRINE

- ☐ THYROID TROUBLE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ DIABETES
- ☐ EXCESSIVE THIRST OR HUNGER
- ☐ EXCESSIVE URINATION
- ☐ RECURRENT INFECTION

PSYCHIATRIC

- ☐ NEUROSES
- ☐ TENSION, STRESS
- ☐ MOOD CHANGES, INCLUDING DEPRESSION
- ☐ MEMORY PROBLEMS

CONTINUE ON NEXT PAGE

21. DO YOU HAVE OR HAVE YOU EVER HAD:

- ☐ SLEEP DISORDER, SNORING OR EXCESSIVE DAYTIME SLEEPINESS
- ☐ CANCER WHERE________________________
- ☐ RADIATION (X-RAY) TREATMENT FOR CANCER OF THE HEAD & NECK
- ☐ CHEMOTHERAPY
- ☐ MRSA - STAPH INFECTION
- ☐ ANY DISEASE, DRUGS OR TRANSPLANT OPERATION THAT HAS DEPRESSED YOUR IMMUNE SYSTEM
- ☐ ANY MEDICAL CONDITION NOT MENTIONED THAT YOU FEEL IS IMPORTANT
- ☐ ANYTHING THAT YOU WOULD LIKE TO DISCUSS PRIVATELY WITH THE DOCTOR

COMMENTS

I CERTIFY THAT, TO MY KNOWLEDGE, THIS INFORMATION IS ACCURATE AND CORRECT. I UNDERSTAND THAT FAILURE TO ANSWER TRUTHFULLY AND ACCURATELY COULD AFFECT THE OUTCOME OF TREATMENT IN A NEGATIVE WAY.

____

SIGNATURE PATIENT. PARENT OR LEGAL GUARDIAN **DATE**

____

DOCTOR'S SIGNATURE **DATE**

HARDWICK & SON PRINTING REORDER #12603

Southeastern Oral - Maxillofacial & Facial Cosmetic Surgery Center, P.C.

PATIENT'S NAME ______________________ DATE OF BIRTH ______________ AGE____ SEX: M____ F ____

MAILING ADDRESS ______________________ CITY ______________ STATE ________ ZIP __________

STREET ADDRESS ______________________ CITY ______________ STATE ________ ZIP __________

PATIENT SS# ______/______/______ HOME PHONE: (   ) ______________ CELL PHONE (   ) ______________

MARITAL STATUS: MARRIED ______ SINGLE ______ DIVORCED ______ WIDOWED ______ SPOUSE'S NAME: ______________

EMPLOYER: ______________________ WORK PHONE (   ) ______________

EMPLOYER ADDRESS: ______________ CITY: ______________ STATE: __________ ZIP: __________

SCHOOL NAME: ______________________ FULL TIME STUDENT? YES __________ NO __________

EMERGENCY CONTACT: ______________ PHONE: ______________ RELATION: ______________

E-MAIL ADDRESS: ____

(Patient or responsible party if patient a minor)

REFERRED BY:

NAME: ______________________ ADDRESS: ______________________

PLEASE NOTE: THE PARENT/GUARDIAN ACCOMPANYING MINORS WILL BE RESPONSIBLE FOR PAYMENT.

RESPONSIBLE PARTY: ______________________ RELATIONSHIP TO PATIENT: ______________

ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: __________

PHONE: (   ) ______________ SOCIAL SECURITY #: ______/______/______ BIRTHDATE: ______________

EMPLOYER: ______________________ WORK PHONE (   ) ______________

EMPLOYER ADDRESS: ______________ CITY: ______________ STATE: __________ ZIP: __________

DENTAL INSURANCE COMPANY: ____

INSURANCE POLICY HOLDER: ______________________ PHONE: (   ) ______________

ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: __________

SOCIAL SECURITY #: ______________________ DOB: ______________

CONTRACT #: ______________ GROUP #: ______________

EMPLOYER: ______________________ WORK PHONE (   ) ______________

EMPLOYER ADDRESS: ______________ CITY: ______________ STATE: __________ ZIP: __________

MEDICAL INSURANCE COMPANY: ____

INSURANCE POLICY HOLDER: ______________________ PHONE: (   ) ______________

ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: __________

SOCIAL SECURITY #: ______________________ DOB: ______________

CONTRACT #: ______________ GROUP #: ______________

EMPLOYER: ______________________ WORK PHONE (   ) ______________

EMPLOYER ADDRESS: ______________ CITY: ______________ STATE: __________ ZIP: __________

HARDWICK & SON PRINTING REORDER #5027-1

FINANCIAL POLICY

I have provided the demographic information on this form and certify that I am the patient or legal guardian of the patient. I authorize the release of all medical records to my referring and family physician and to my insurance company. I will allow the fax transmittal of records, if necessary. I understand that payment of charges incurred is due at the time services are rendered, unless other financial arrangements have been made prior to treatment. I understand that if my account becomes delinquent it may be placed for collection. Further, I agree to the following terms regarding any outstanding balance that I owe: (1) I will incur interest at the rate of 1 & 1/2 percent per month (18% PER ANNUM); (2) I agree and hereby consent that I will be responsible for reasonable collection costs and attorney's fees and costs of court incurred by this office in the collection of same, whether such outstanding balance is satisfied prior to, after initiation of a lawsuit, or after a judgment has been issued in a lawsuit; and (3) I agree and hereby consent that any lawsuit and/or legal proceeding surrounding the outstanding balance and debt, and fees and costs thereon, shall be initiated and litigated in the court of appropriate jurisdiction of Houston County, Alabama, and I hereby waive any and all defenses and/or objections to said jurisdiction and waive my rights to claim exemption. By signing below, I consent to the terms contained herein and affirmatively acknowledge that I have read the same before signing. Furthermore, I agree that if a cell phone number has been provided I can be contacted regarding my balance on said cell phone. Additionally, if I reside in Florida I agree to waive my rights to any exemption that would prohibit a wage garnishment should same become necessary to secure payment of any outstanding balance. I also agree that at any time if my balance has not been paid according to policy I understand my credit history will be investigated and thoroughly reviewed.

____

Patient or Legal Guardian / Date

ADVANCE DIRECTIVES

Southeastern Oral-Maxillofacial & Facial Cosmetic Surgery Center, P.C. is an outpatient surgery center that is limited to elective surgery only and performs no high-risk surgical procedures.

Therefore, this practice will not acknowledge advance directives of any patient while in this practice. In the event of an emergency, the patient will be stabilized and transferred to a hospital as soon as possible.

I hereby acknowledge and understand the above statement.

____

Patient or Legal Guardian / Date

____

Witness / Date

SOUTHEASTERN ORAL-MAXILLOFACIAL & FACIAL COSMETIC SURGERY CENTER, P.C.

DISCLOSURE OF LIABILITY FOR NON-COVERED SERVICES

As participants with Blue Cross Blue Shield of Alabama, Medicare, United Concordia, Southland Dental, Metlife and Delta Dental, we will verify your insurance benefits via telephone or internet and inform you of expected benefits. Occasionally, the dental/medical review board for the insurance company will determine a service to be "non-covered" or to be medically unnecessary. (Example: our physicians may feel IV sedation/anesthesia is in the best interest of the patient, but the insurance company deems it unnecessary.)

This is to inform you that if your insurance company excludes coverage for services they render "non-covered" or medically unnecessary, the patient and/or responsible party will be held responsible for the cost of such services less any contractual adjustments.

Procedures falling into the above category may include but are not limited to:

CONSULT / X-RAY	**BIOPSY**	____________________
ANESTHESIA	**EXTRACTIONS**	____________________

Date:________________ Signature:__________________________