Nebraska Oral & Facial Surgery

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Date:_____

How did you hear about us? (circle): Website | Social Media | Drive By | Referred by Dentist/Physician | Friend: _____ | Other: _____

Do you have a family or friend who has been seen at Nebraska Oral & Facial Surgery? ☐Yes ☐ No ☐ Unsure; If yes, who? _____

Patient Information

☐Mr. ☐Mrs. ☐Ms. First Name:_____M.I.:_____ Last Name:_____

Sex: ☐Male ☐Female Birth Date:_____ Age:_____ Soc. Sec. #:_____ Email:_____

Street:_____ City:_____ State:_____ Zip: _____

Primary Tel: _____Home/ Cell / WorkSecondary Tel.: (____) _____ Home / Cell / Work

Referred By: _____ Dentist:_____ Orthodontist:_____

Medical Doctor:_____ Driver's Lic. #:_____ Employer: _____

Emergency Contact:_____ Tel.: (____) _____ Relationship: _____

Insurance policy holder, spouse, or guarantor information

Name:_____ Soc. Sec.#: _____ Birth Date:_____

Street:_____ City:_____ State:_____ Zip: _____

Primary Tel: _____Home / Cell / Work Secondary Tel.: (____) _____ Home / Cell / Work

Employer:_____ Relationship to patient: _____

Primary Dental Insurance Company

Insurance Company Name:_____ Group #:_____ Group Name:_____

Policy ID #:_____ Policy Holder:_____ Sex: ☐Male ☐Female

Birth Date:_____ Soc. Sec.#: _____ Employer:_____

Primary Medical Insurance Company

Insurance Company Name:_____ Group #:_____ Group Name:_____

Policy ID #:_____ Policy Holder:_____ Sex: ☐Male ☐Female

Birth Date:_____ Soc. Sec.#: _____ Employer:_____

Social History

Do you smoke?:☐Yes ☐No If so, how much?:_____pack(s)/day Do you use chewing tobacco?: ☐Yes ☐No

Do you have a history of alcohol abuse?:☐Yes ☐No How many alcoholic drinks do you consume per week?:_____

Do you have a history of drug abuse?:☐Yes ☐No

Surgical History

Have you had any surgeries in the past?:☐Yes ☐No Describe:_____

Have you or a family member had any unusual or serious reactions to general anesthesia? ☐Yes ☐No

Do you have a prosthetic joint / implant? ☐Yes ☐No If so, describe where:_____

Have you had a heart valve replacement or vascular graft?:☐Yes ☐No Describe:_____

Medical History

Height:_____ Weight:_____ Have there been any recent changes in your general health?: ☐Yes ☐No

Are you under the care of a physician?:☐Yes ☐No For what are you being treated?:_____

Have you had any recent illness or been hospitalized?_____

Have you ever had or do you currently have (please check yes or no for each one)…

	Yes	No	Notes		Yes	No	Notes
Rheumatic fever				Convulsions, epilepsy			
Damaged heart valves				Stroke			
Mitral valve prolapse				*If so, when?*			
Heart murmur				Thyroid Disease			
High blood pressure				*Hypothyroidism*			
Low blood pressure				*Hyperthyroidism*			
Chest pain/angina				Diabetes			
Heart attack(s)				*If so, which type? I II*			
If so, when?				Hypoglycemia / Hyperglycemia			
Irregular heart beat				Kidney disease			
Cardiac pacemaker				Dialysis Treatments			
Heart surgery				Arthritis			
If so, when?				Osteoporosis			
Pneumonia, bronchitis				Osteopenia			
If so, when?				Osteonecrosis			
Asthma				Stomach ulcers			
COPD				Contagious diseases			
Emphysema				Sexually transmitted diseases			
Disability - Physical / Mental				*Please specify*			
Psych/Behavior Disorder				Immunosuppressed			
Please specify				Infectious Mononucleosis			
Sleep Apnea				Tumor or growth			
Use CPAP?				Cancer			
Blood disorder (anemia)				*Please specify*			
Bleeding tendency				Radiation or Chemotherapy			
Hepatitis				Multiple Sclerosis			
If so, which type? A B C				Eye disease or glaucoma			
Jaundice or liver disease				Fainting spells			
Blood transfusion				Tuberculosis			

WOMEN ONLY -The next section is for women only, men please continue below

Is there a possibility of pregnancy?:☐Yes ☐No If yes, expected delivery date:_____ Name of OB: _____

Are you nursing?:☐Yes ☐No Are you taking birth control pills?: ☐Yes ☐No

Family History

Is there a family history of: Cancer ☐Yes ☐No Diabetes ☐Yes ☐No Heart Disease ☐Yes ☐No

If you are having IV sedation…

Have you had anything to eat or drink (including water, gum, and mints) in the last 8 hours?:☐Yes ☐No

Who is driving you home?:_____

Medications

Are you now taking any of the following?	Yes	No
Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, GinkoBiloba, Xarelto, Pradaxa, Eliquis)		
Diet pills		
Any natural product, herbal supplement, or homeopathic remedy		
Have you ever taken any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Boniva)?		
Have you ever taken tranquilizers, sleeping pills, anti-depressants, and / or narcotics on a regular basis?		

Please list all medications you are currently taking.

Allergies

Are you allergic to, or had a reaction to…	Yes	No	Notes	**Please list any other allergies & reaction**
Local anesthetic (numbing medicine)?				
Penicillin				
Other antibiotics				
Sulfa Drugs				
Anesthetics or sedatives				
Aspirin				
Codeine or other narcotics				
Latex				
Soy				
Eggs / Yolk				
Sulfites				

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or emissions that I have made in the completion of this form.

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical, insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of benefits to the doctor named unless otherwise payable to me.

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of patient: (Patient or Guardian if minor) **X**_____ **Date: X** _____