SOUTHWEST ORAL AND MAXILLOFACIAL SURGERY

Dr. Wai Pong Ng D.M.D.

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PATIENT INFORMATION: ___ Mr. ___ Mrs. ___ Ms. ___ Dr.

First Name: _____ M.I. _____ Last Name: _____

Sex: _____ M _____ F DOB: _____ Age: _____ SSN: _____- _____-_____

Street: _____ Apt: _____ City/State/ Zip: _____

Home #: _____ Cell #: _____

Have you been a patient in our practice? _____Y _____N Referred by: _____

Dentist: _____ Orthodontist: _____ Medical Dr.: _____

Employer: _____

In case of emergency, please contact: _____Telephone: _____ Relation: _____

PHARMACY:

Name: _____ Location: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Name: _____ SSN: _____- _____- _____ DOB: _____

Street: _____ Apt: _____ City/State/ Zip: _____

Employer: _____ Telephone #: _____

Email: _____

Employer: _____

Insurance Company Name: _____

Address: _____

Telephone: _____

Group Name: _____

Group Number: _____

Insured Party: _____

Relation: _____

DOB: _____ SSN: _____- _____ - _____

PRIMARY DENTAL INSURANCE INFORMATION:

Employer: _____

Insurance Company Name: _____

Address: _____

Telephone: _____

Group Name: _____

Group Number: _____

Insured Party: _____

Relation: _____

DOB: _____ SSN: _____- _____ - _____

PRIMARY MEDICAL INSURANCE INFORMATION:

SECONDARY DENTAL INSURANCE INFORAMATION:

Employer: _____

Insurance Company Name: _____

Address: _____

Telephone: _____

Group Name: _____

Group Number: _____

Insured Party: _____

Relation: _____

DOB: _____ SSN: _____- _____ - _____

SECONDARY MEDICAL INSURANCE INFORMATION:

Employer: _____

Insurance Company Name: _____

Address: _____

Telephone: _____

Group Name: _____

Group Number: _____

Insured Party: _____

Relation: _____

DOB: _____ SSN: _____- _____ - _____

HEALTH HISTORY:

	YES	NO
Are you in good health?		
Are you in the care of a physician?		
Have you had any illness, operation or been hospitalized in the last 5 years?		
Do you have any know allergies?		
Has a physician or dentist recommended you take antibiotics prior to your dental treatment?		
Are you taking or have you taken bone density medications or bisphosphonate in the last 12 years?		
Do you have any growths or sore spots in your mouth?		
Do you have a prosthetic joint or implant?		
Have you ever had a heart valve replacement or vascular graft?		
Have you ever had general anesthesia?		
Have you or a family member had any unusual or serious reactions to general anesthesia?		
Reason for today's office visit:		
Height:	Weight:	

There is a family History of:	YES	NO
Cancer		
Diabetes		
Heart Disease		
Anesthesia Problems		
ARE YOU NOW TAKING?		
Any kind of medication, drugs, pills?		
Blood Thinners? Coumadin, Plavix, Aspirin, Vitamin E, Fish Oil?		
Tranquilizers, sleeping pills, anti-depressants or narcotics on a regular basis?		
ARE YOU ALLERGIC TO OR HAD A REACTION TO? :	YES	NO
Local anesthetic (numbing medicine)?		
Penicillin?		
Other Antibiotics?		
Sulfa Drugs?		
Sodium pentothal/ Valium/ other tranquilizers?		
Aspirin?		
Amoxicillin?		
Codeine or other narcotics?		
Other medications?		
Latex?		
Soy?		
Eggs/ Yolk?		
Sulfates?		
Other:		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO
Rheumatic Fever?		
Damaged heart valve?		
Mitral valve prolapse?		
Heart Murmur?		
High Blood Pressure?		
Low Blood Pressure?		
Chest Pain/ Angina?		
Heart Attack ('s)?		
Irregular Heartbeat?		
Cardiac Pacemaker?		
Heart Surgery?		
Pneumonia, bronchitis?		
Chronic Cough?		
Asthma?		
Hay Fever? Sinus problems?		
Snoring/ Sleep apnea?		
Difficult breathing?		
Tuberculosis?		
Emphysema?		
Do you smoke?		
Number of packs per day?		
Do you use chewing tobacco?		
Blood Transfusion?		
Bruise Easily?		
Blood disorder such as Anemia??		
Bleeding Tendency?		
Contact Lenses?		
Mental health problems?		
Removable dental appliance?		

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO
Abnormal bleeding?		
Hepatitis, Jaundice or liver disease?		
Infectious mononucleosis?		
Gallbladder trouble?		
Fainting Spells?		
Convulsions/ epilepsy?		
Stroke?		
Thyroid Trouble?		
Diabetes?		
Low Blood Sugar?		
Kidney trouble?		
High Cholesterol?		
Are you on dialysis?		
Swollen Ankles/ Arthritis?		
Osteoporosis/Osteopenia?		
Osteonecrosis?		
Stomach Ulcers/ acid reflux?		
Contagious Diseases?		
Sexually transmitted disease?		
Problems with Immune system?		
Delay in healing?		
Tumor or growth?		
Cancer / radiation therapy?		
Chemotherapy?		
Chronic Fatigue?		
Night Sweats?		
History of alcohol/ drug abuse?		
Eye disease?		
Pain or clicking of Jaws?		

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ☐ Provided a list.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

If you are having surgery TODAY, have you had anything to eat or drink in the last (8) hours? ____ Y _____ N

Is there any condition concerning your health that the Doctor should be told about? ____ Y _____ N

If yes, Describe: _____

Do you wish to speak to the Doctor privately about anything? _____Y _____N

WOMEN ONLY:

Is there a possibility of pregnancy? _____ Y _____ N

Expected delivery date? _____

Are you taking birth control pills? _____ Y _____ N

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 doctor, or any other member of his/her staff for any errors or emission that I have made in the completion of this from.

Signature of Patient (Parent or Guardian if Minor) *Date*

FEE & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. An estimate of the charge for any procedure or surgery you may require will be given to you. If you have dental and /or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information of 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 that charge. *It is your responsibility to pay any deductible amount, co-insurance or any other balanced not paid for by your insurance company.* You will be responsible for all collection costs, attorney fees, and court costs.

Signature of Patient (Parent or Guardian if Minor) *Date*

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 the x-rays required as a necessary part of my examination. In addition, if medically necessary, I authorize the release of any information acquired int eh course of my examination and treatment to my other doctors and/or insurance carriers.

Signature of Patient (Parent or Guardian if Minor) *Date*

In office use only

Reviewed By *Date*