Patient Information Form

Charles B. Felts, DDS
Specialist in Oral and Maxillofacial Surgery

Name: Dr. /Mr. /Mrs. /Ms. _____
(Circle One) **First** **Middle** **Last**

Address: _____
City: _____ State: _____ Zip: _____
DOB: ____/____/_____ Age: _____
Social Security #: _____-_____-_____
Employer: _____
Occupation: _____

Cell Phone: (____) _____-_____
Home Phone: (____) _____-_____
Work Phone: (____) _____-_____
Email: _____@_____
Preferred contact method:
☐ Text ☐ Cell ☐ Home ☐ Work ☐ Email
May we leave you a voicemail? ☐ YES ☐ NO

Referral Information

Who referred you to our office? _____ Name of General Dentist: _____
Is another family member or relative a patient at our office? **YES** **NO** Name: _____

Person Financially Responsible for Account

Name: _____ Relationship to Patient: _____
Address: _____

Dental Insurance

Do you have Dental Benefits? (Circle One) **YES** **NO** *If yes, please provide card to be copied.*

Primary Insurance Company: _____
Employer: _____
Employee's Name: _____
Employee DOB: _____/_____/_____
Social Security #: _____-_____-_____
Member ID #: _____

Secondary Insurance Company: _____
Employer: _____
Employee's Name: _____
Employee DOB: _____/_____/_____
Social Security #: _____-_____-_____
Member ID#: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Patient Signature: _____ **Date:** _____/_____/_____

Print Name: _____

Medical History Form

RIVERBEND ORAL SURGERY

Patient:_____

DOB:_____

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important relationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be kept confidential.*

Reason for your office visit today:_____

Height _____ Weight _____ Age_____

	YES	NO
Are you under the care of a physician? . . . . . Date of last visit_____	☐	☐
Physician's Name:_____		
Hospitalized or major operations in the last 5 years?.	☐	☐
If so, describe_____		
Have you ever had IV Sedation or General Anesthesia?	☐	☐
Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?	☐	☐

MEDICAL PROBLEMS:	YES	NO	NOTES
Heart Problems/Surgery			
A fib/ Irregular Heartbeat			
Artificial Valve/Pacemaker			
Chest Pain/Angina			
Stroke			
High Blood Pressure			
Hyperlipidemia			
Asthma/Bronchitis			
Emphysema			
Difficulty Breathing/Lung trouble			
Pneumonia/Tuberculosis			
Tobacco Use			
Alcohol or Drug Use			
Sleep Apnea/CPAP			
Sinus Problems/Allergies			
Anemia/Sickle Cell			
Abnormal Bleeding			
Thyroid Trouble			
Diabetes			

MEDICAL PROBLEMS:	YES	NO	NOTES
Kidney Problems/Dialysis			
Hepatitis/Liver Disease			
STD/Contagious Diseases			
HIV/AIDS			
Immune Problems/Arthritis			
Osteoporosis/Osteopenia			
Joint Replacement			
Acid Reflux/Ulcers			
Healing Problems			
Radiation/Chemotherapy			
Tumors/Cancer			
Epilepsy/Seizures			
Neurological Disorders			
Fainting/Dizziness			
Depression/Anxiety			
Glasses/Contacts			
Vision Problems			
Pregnant/Nursing			
Birth Control Pills			

Please List Surgeries and Approximate dates below:

MEDICATIONS:

ARE YOU NOW TAKING?	YES	NO	NOTES
Blood thinners (Coumadin, Plavix, Aspirin, Eliquis, Xarelto, etc)?			
Tranquilizers, sleeping pills, antidepressants, and/or narcotics on a regular basis?			
Any natural product, herbal supplement, or homeopathic remedy?			

ARE YOU NOW TAKING?	YES	NO	NOTES
Are you taking, or have you ever taken bone density meds, bisphosphonates or RANKL inhibitors such as Denosumab, Fosamax, Boniva, Actonel, Prolia, Zometa, or Reclast in the past 10 years?			
Diet pills?			

Please list any medications you are currently taking:		
Medication	Dose	Frequency

ARE YOU ALLERGIC TO OR HAD A REACTION TO:	YES	NO	REACTION
Local anesthetic (numbing meds)?			
Penicillin?			
Sulfa Drugs?			
Amoxicillin?			
Other Antibiotics?			
Codeine or other narcotics?			
Ibuprofen/NSAIDS?			
Latex?			
Egg/Yolks?			

Please list any other drug allergies and reaction:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No

Who is driving you home?_____

Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☐ No

_____

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

☐ Yes ☐ No

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

_____ _____

Signature of Patient **Date**

RIVERBEND ORAL SURGERY

General Consent

Oral & maxillofacial surgery is surgical treatment to correct a wide spectrum of diseases, injuries, and defects in the head, neck, face, jaws, and the hard and soft tissues of the oral and maxillofacial region. Treatment is dependent on many factors including the patient's general health and willingness to perform proper oral hygiene. Naturally, we will make every effort to keep you informed of your needed treatment. Your involvement and understanding are very important in the success of your treatment.

Oral & maxillofacial surgical treatment involves complex procedures, and during the course of treatment unusual and unanticipated problems can arise. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic material deemed appropriate by the doctor. I authorize that such diagnostic material may be released to third party payors and/or other health care professionals and can be used for professional education without identification. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that both surgery and using medications has certain risks including: redness, swelling, pain, itching, vomiting, dizziness, drowsiness, miscarriage, cardiac arrest, and/or lack of coordination. During treatment, possible complications can arise including bleeding, swelling, prolonged/permanent numbness, and sensitive and/or loose teeth. I understand that I can ask for a complete listing of any possible complications.

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR will be automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

I authorize Riverbend Oral Surgery to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I authorize Riverbend Oral Surgery to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to Riverbend Oral Surgery the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

_____ _____/_____/_____

Signature Date

Acknowledgment of Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

I received a copy of the Notice of Privacy for Riverbend Oral Surgery in accordance with the federal requirements of HIPPA. I hereby authorize, as indicated by my signature below, Riverbend Oral Surgery to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the General Patient Consent form above.

_____ _____/_____/_____

Signature Date

_____

Print Name