

INFORMATION SHEET: PLEASE PRINT AND ANSWER ALL QUESTIONS IN FULL

Title (circle) Mr. Mrs. Ms. Dr. First Name _____ MI _____ Last Name _____
SSN# _____ DOB: _____ Age: _____ Female Male
Address: Street: _____
City: _____ State: _____ Zip Code: _____
Driver License #: _____ e-mail address: _____
Home Phone #: _____ Work #: _____ Cellular #: _____ Pager #: _____

Employer Name: _____ Phone number: _____ Ext. _____
Address: Street: _____
City: _____ State: _____ Zip Code: _____

Spouse / **Parent Information:** Name (First Middle Initial Last): _____ Father Mother
Date of Birth: _____ Age: _____ Social Security #: _____ Drivers License #: _____
Address: Street: _____ Apt _____ Female Male
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cellular #: _____ Beeper #: _____ e-mail address: _____

Employer Name: _____ Phone number: _____ Ext. _____
Address: Street: _____
City: _____ State: _____ Zip Code: _____

Referral Information:

Who referred you to our office (Name/Address): _____
Dentist: Address: Street: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Physician (MD) Address: Street: _____ Phone: _____
City: _____ State: _____ Zip Code: _____

In the event of an emergency, call: Name: _____ Phone: _____
Address: Street: _____
City: _____ State: _____ Zip Code: _____

Dental Insurance Information: Plan Name: _____
Plan Address: Street: _____
City: _____ State: _____ Zip Code: _____
Plan Telephone #: _____ SSN or ID #: _____ DOB: _____

Medical Insurance Information: Plan Name: _____
Plan Address: Street: _____
City: _____ State: _____ Zip Code: _____
Plan Telephone #: _____ SSN or ID #: _____ DOB: _____

Secondary Insurance Information (Plan Name): _____ SSN or ID #: _____

ACCIDENT OR WORK RELATED INJURIES ONLY:
Date of Accident: _____
Attorney: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone #: _____

WORKMAN'S COMP Yes No
Claim #: _____
Policy Name: _____
Case Manager: _____
Telephone #: _____

HOW DO YOU INTEND TO PAY YOUR BILL TODAY?: PERSONAL CHECK; MASTERCARD; VISA ; AM.EXPRESS; CASH ; OTHER

INFECTION CONTROL CHARGES: PATIENTS WHO ARE HAVING A SURGICAL PROCEDURE PERFORMED WILL BE CHARGED \$20.00 TO COVER THE COSTS OF DISPOSABLES AND INFECTIOUS WASTE REMOVAL.

INSURANCE AUTHORIZATION: AS PER MY MEDICAL INSURANCE PLAN, I AGREE AND REQUEST THAT ALL PAYMENTS BE MADE DIRECTLY TO THE PROVIDERS: DR. FRIEDMAN, DR. PAYTON, DR. CARDENAS, DR TENDLER OR ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER, FOR ALL SERVICES RENDERED. I ALSO AUTHORIZE THE PROVIDER(S) TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR INTERMEDIARIES OR CARRIERS, ANY INFORMATION NEEDED FOR THIS CLAIM OR RELATED MEDICARE CLAIMS. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED. THIS AUTHORIZATION WILL ALSO APPLY TO ALL PRIVATE INSURANCE CLAIMS USED BY THE PROVIDERS. I HAVE READ AND UNDERSTAND ORAL FACIAL RECONSTRUCTION AND IMPLANT CENTER'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

Signed: _____ **Witness:** _____ **Date** _____

HEALTH HISTORY: (ANSWER ALL QUESTIONS AND SIGN BELOW)

List all allergies to medicines or foods: _____

List all Medication you are taking now: _____

List all medical problems: _____

List all previous operations: _____

In your own words, why are you here to see the doctor: _____

FH: Is there in your Family any history of **(Please circle)**: Diabetes, Hypertension, Cancer, stroke, Anesthesia complications, Heart Disease, Tuberculosis, Psychiatric illness, Asthma, bleeding disorders.

ROS: Have you experienced any **(Please circle)**: recent change in weight or appetite, cephalgia, migraines, blurriness, diplopia, photophobia, vision changes, tinnitus, unexplained epistaxis, nasal fractures, sore throat, dysphagia, neck masses, pain, or stiffness, chronic cough, hemoptysis, angina, palpitations, diarrhea, nausea & vomiting. Any history of anesthesia, paresthesia.

(Please circle)

Y N Do you smoke? How much? _____	Y N Do you drink? How much? _____
Y N Do you use illegal recreational drugs?	Y N Have you taken any diet related medications in the last 5 years? If yes, which one: _____
Y N Are you pregnant? If yes, what month? _____	Y N Do you have a DO NOT RESUSCITATE (DNR) order
Y N Do you have a living will	Y N Do you suffer from sinus problems?
Y N Are you allergic to Latex?	Y N Are you HIV positive?
Y N Is your immune system compromised?	Y N Are you taking aspirins? If so how many per day? _____
Y N Have you ever had a blood transfusion?	Y N Do you have a prosthetic heart valve?
Y N Do you have heart disease?	Y N Do you have a heart murmur?
Y N Do you have angina?	Y N Have you ever had a stroke?
Y N Are you on any blood thinners? If yes, do you have you nitroglycerin with you? Y N	Y N Do you have any artificial Prosthesis?
Y N Do you have high blood pressure?	Y N Have you ever had an anesthesia complication?
Y N Do you have diabetes?	Y N Do you have any thyroid disorders?
Y N Have you ever had hepatitis?	Y N Do you have anemia?
Y N Do you have asthma, bronchitis or shortness of breath?	Y N Have you ever had tuberculosis?
Y N Do you have osteoporosis? If yes, what medication are you taking: _____	Y N Do you have kidney disease?
Y N Have you ever had cancer or been diagnosed with a tumor? If so, where: _____	Y N Have you had a kidney removed?
Y N Have you ever received irradiation therapy? If yes, to which part of your body: _____	Y N Are you on dialysis?
Y N Have you ever received chemotherapy? If yes, what medication was used: _____	Y N Are you on any steroids or cortisone? If yes, what type: _____
Y N Have you ever had any psychiatric care?	Y N Have you been hospitalized in the past 3 years? If so, explain: _____
	Y N Do you have arthritis?
	Y N Do you have any history of Temporomandibular Joint disease?
	Y N Does your Temporomandibular Joint pop or click? If yes, which side: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

OUR OFFICE POLICY REQUIRES A CHARGE FOR ALL CONSULTATIONS AND SERVICES TO BE PAID IN FULL AT THE TIME TREATMENT IS RENDERED.

PAYMENT IS ACCEPTED IN THE FORM OF PERSONAL CHECKS (with proper identification), CASH, MASTERCARD, VISA OR AMERICAN EXPRESS. IF YOUR INSURANCE REQUIRES A PREDETERMINATION FOR TREATMENT AS WELL A FULL REPORT, YOU WILL BE CHARGED \$50.00 TO COVER MAILINGS, DUPLICATIONS AND TELEPHONE CALLS. AS WITH ALL INSURANCE, THERE IS A DEDUCTIBLE THAT MUST BE MET. YOU ARE RESPONSIBLE FOR THAT DEDUCTIBLE AS WELL AS ANY OUTSTANDING AMOUNTS DUE. IF YOU ARE A MEMBER OF AN HMO, YOUR FEE WILL BE ADJUSTED ACCORDING TO YOUR INDIVIDUAL CONTRACT. CO-PAYMENTS ARE YOUR RESPONSIBILITY.

I, _____, ACKNOWLEDGE AND AGREE THAT I AM RESPONSIBLE FOR THE FEE CHARGED FOR SERVICES RENDERED. ANY INSURANCE COVERAGE REIMBURSEMENT WILL BE MY RESPONSIBILITY TO OBTAIN. I WILL BE PROVIDED A STATEMENT OF ANY CHARGES INCURRED AND IF I DISPUTE THE BALANCE, I WILL NOTIFY THE OFFICE, IN WRITING WITHIN FIVE DAYS OF RECEIPT OF THE STATEMENT. IF MY ACCOUNT BECOMES DELINQUENT, I AGREE TO BE SOLELY RESPONSIBLE FOR ALL RE-BILLING CHARGES, INTEREST ON THE BALANCE AT THE STATUTORY RATE OF 10 %, COLLECTION COSTS, COURT COSTS AND ATTORNEY'S FEES. IF MY CHECK IS RETURNED FOR ANY REASON, I AGREE TO PAY THE BALANCE IN FULL PLUS THE BANK SERVICE CHARGE WITHIN 10 DAYS OF RECEIPT OF NOTICE.

I HAVE READ THIS ENTIRE FORM AND HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY ABILITY. UPON SIGNING THIS DOCUMENT, I AGREE THAT I HAVE NOT BEEN TAKING ANY MIND ALTERING MEDICATIONS.

Signed: _____ Witness: _____ Date _____

Reviewed by: Dr. Kurt Friedman Dr. Kevin Payton Dr. Luis Cardenas Dr. Alfredo Tendler