

INFORMATION SHEET: PLEASE PRINT AND ANSWER ALL QUESTIONS IN FULL

Title (check) 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?: (PLEASE CIRCLE) MASTERCARD VISA AM.EXPRESS CASH CHECK 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 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 check)**: Diabetes Hypertension Cancer Stroke Anesthesia complications
 Heart Disease Tuberculosis Psychiatric illness Asthma,

ROS: Have you experienced any **(Please check)**: 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 check)

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