

PATIENT INFORMATION

PLEASE PRINT

Title: (Mr., Mrs., Ms.) First Name: _____ Middle Initial: _____ Last Name: _____

Sex: Male Female Date of Birth: _____ Age: _____ Social Security No: _____

Mailing Address: _____ City: _____ State / Zip: _____

Home Telephone: (_____) _____ Work Telephone: (_____) _____ Ext.: _____

Physician: _____ Dentist: _____

Who referred you to our office? _____

Who will be responsible for your account? Relation: Self Spouse Mother Father _____

Name: _____ Social Security No.: _____ Home Telephone: (_____) _____

Street: _____ City: _____ State / Zip: _____

Employer: _____ Telephone No.: (_____) _____

Student?: Full Time Part Time School Name / Address: _____

Married Divorced Legally Separated Widow Single

Employed: Full Time Part Time Retired **If Medicare Beneficiary, MEDICARE #:** _____

INSURANCE COMPANY:

Name: _____

Address: _____

Telephone (_____) _____

Does your plan cover: Medical Dental Both

Group No.: _____ Group Name: _____

Local: _____

Is this an Employer Health Insurance Plan? Yes No

INSURANCE COMPANY:

Name: _____

Address: _____

Telephone (_____) _____

Does your plan cover: Medical Dental Both

Group No.: _____ Group Name: _____

Local: _____

Is this an Employer Health Insurance Plan? Yes No

INSURED PARTY:

Name: _____

Relation to Insured: Self Spouse Child Other

Sex: Male Female Date of Birth: _____

Street: _____

City/State/Zip: _____

Telephone No.: _____

Social Security No: _____ ID No: _____

Employer: _____

INSURED PARTY:

Name: _____

Relation to Insured: Self Spouse Child Other

Sex: Male Female Date of Birth: _____

Street: _____

City/State/Zip: _____

Telephone No.: _____

Social Security No: _____ ID No: _____

Employer: _____

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 charges for any procedure or surgery you may require will be given to you prior to the care provided. If you have any dental or medical insurance we will be glad to fill out the proper forms but please complete the identifying information in this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and 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.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to Dr. Blanton of the insurance benefits otherwise payable to me.

Date: _____ Signature: _____

HEALTH HISTORY

Thank you for answering the following questions. Your answers are for our records only and will be considered confidential. It is important that your surgeon has the necessary information to evaluate and treat your condition(s) properly.

.....
Are you in good health? Height _____ Weight? _____ Yes No
Have there been any changes in your general health in the past year? Yes No
Are you under the care of a physician? Yes No
Date of last visit? _____ If so, for what are you being treated? _____
.....

Have you had any illness, operation, or been hospitalized in the past three years? Yes No
.....

Have you had or do you currently have/use any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Damaged heart valves | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Low blood sugar |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Are you on dialysis? |
| <input type="checkbox"/> Heart Attack(s) | <input type="checkbox"/> Gallbladder trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Joint disease/arthritis |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Eye disease/glaucoma | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Bronchitis/Chronic cough | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood transfusions(s) | <input type="checkbox"/> A tumor or growth |
| <input type="checkbox"/> Hay fever/Sinus problems | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> Mental problems |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Habit-forming drugs | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Do you smoke? How much? _____ | | <input type="checkbox"/> Contact lenses |
-

Are you now taking: Blood thinners/Coumadin Cortisone/Steroids Tranquilizers
 Non-prescribed drugs

Are allergic to or had a reaction to: Local anesthetics Penicillin Sulfa drugs
 Sedatives Aspirin Iodine Codeine or other narcotics Other

Please list all other medications that you are currently taking:

.....

Women: Is there a possibility that you may be pregnant? Yes No
Estimated delivery date? _____
Are you nursing? Yes No
Are you taking birth control pills? Yes No
.....

is there any other condition concerning your health or your famil/s anesthetic history that the doctor should know? Yes No

I certify that the information provided above is true and correct.

Date: _____ Signature (Patient or Guardian) _____

ED BLANTON, DDS, P.A.
ORAL AND MAXILLOFACIAL SURGERY

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