PENINSULA
ORAL AND FACIAL SURGERY

Date _____

Patient:
(Mr., Mrs., Ms., Dr.)

First Name _____ M.I. ____ Last Name _____ Preferred Name _____

Who will be responsible for your Account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Sex ☐ Male ☐ Female Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Tel. # (___)_____ Business Tel. # (___)_____ Ext. ____ Cell Phone # (___)_____ Email _____

Dentist _____ Medical Doctor _____ Referred by _____

Have you ever been a patient of our practice? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Ins. Co. Name _____

Address _____ Phone (___)_____

Group # _____ ID # _____

Insured Party _____ Relation _____

Sex ☐ Male ☐ Female Date of Birth _____

Social Security # _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Ins. Co. Name _____

Address _____ Phone (___)_____

Group # _____ ID # _____

Insured Party _____ Relation _____

Sex ☐ Male ☐ Female Date of Birth _____

Social Security # _____

HEALTH HISTORY

To our patients: Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records and will be kept confidential.

	YES	NO
Are you allergic or sensitive to any drugs? Please list _____	☐	☐
Are you taking any medication? Please list _____	☐	☐
Have you ever been admited to a hospital? _____	☐	☐
Have you had previous surgery? _____	☐	☐
Have you ever had problems with general anesthesia? _____	☐	☐
Have you taken bone density medications, or bisphosphonates such as Fosamax, Boniva, Actonel, Zoometa, Aredia or Reclast in the past 10 years?	☐	☐
Previous treatment for cancer/radioation or chemotherapy _____	☐	☐

Tobacco: Do you smoke? Yes ____ No ____ Chewing tobacco Yes ____ No ____

Do you drink alcohol? No ____ Occ. ____ Mod. ____ Heavy ____

Height _____ Weight _____ Approximate date of last physical exam by your physician _____

HAVE YOU HAD OR CURRENTLY HAVE...

	YES	NO		YES	NO		YES	NO
Joint Replacement?			Damaged Heart Valve?			Anemia?		
Heart Murmur?			Tuberculosis?			Diabetes?		
Rheumatic Fever?			Immune Deficiency?			Asthma?		
Heart Trouble?			Chronic Cough?			Cancer?		
Cardiac Pacemaker?			Difficulty breathing/other lung problems?			Eye disease/glaucoma?		
Kidney Disease?			Bleeding Tendency?			Chest Pain?		
Seizure Disorder?			Irregular heart beat?			Hepatitis?		
Sinus Problems?			High Blood Pressure?			Latex Allergy?		

NOTES

	YES	NO
Are you nursing, pregnant or trying to become pregnant? _____	☐	☐
Do you take birth control pills? _____	☐	☐

Dr. _____ Date _____

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FEES & PAYMENTS

We make every effort to provide you with the finest surgical care and to keep down its cost. We will work with you to maximize your insurance reimbursement for covered procedures and will furnish you an estimate of charge for any procedure or surgery prior to service. Payment for services is due at the time rendered unless other arrangements have been made. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on 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 the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company.**

This signature on file is my authorization for the release of information necessary to process my claim, I also authorize payment to this doctor named of the benefits otherwise payable to me.

Signature

HIPAA RELEASE

All patient records are confidential. A copy of our office privacy policy is available to me upon request.
If anyone may be calling on the patient's behalf, please complete this section.
If you do not wish to add anyone, please complete name & D.O.B and sign & date at the bottom of this section.

Patient Name: _____ Patient D.O.B: ____/____/____

I, _____ give the individuals listed below permission to access all health information/records pertaining
*(Patient **or** Parent/Guardian)*

to the patient named above.

Name	Relation to patient	Date	Initials *(Patient **or** Parent/Guardian)*

Signature

*(Patient **or** Parent/Guardian)*

*(Patient **or** Parent/Guardian)*

At Peninsula Oral and Facial Surgery we think it is important to be transparent with our patients about any industry funding that our doctors receive. You can rest assured that no financial contribution from any industry partner will ever alter your care or our treatment recommendations. Pursuant with the requirements put forth by the California Medical Board any of our patients can find information about any financial support received from industry partners by using the database below. If you have any further questions about this, please do not hesitate to ask your doctor during your consultation.

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov."

Patient or Representative Signature:

Date _____