Berlin ORAL SURGERY

BerlinOralSurgery.com

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information (CONFIDENTIAL)

Date _____

Name _____

Address _____ City _____ State _____ Zip _____

SS# _____ Date of Birth _____ Sex: ❑ M ❑ F

Work Phone _____ Home Phone _____

If Student, Name of School/College _____ City _____ State _____ ❑ Full Time ❑ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Local Emergency Contact: _____ Phone _____

Name of Primary Dentist _____ Date of Last Exam _____

Medical Doctor _____ Office Phone _____ Date of Last Exam _____

Name of Person Responsible for this Account _____ Relationship to Patient _____

Have you or a family member been seen here previously? ❑ Yes ❑ No Name _____

Insurance Information (TO BE COMPLETED BY PATIENT)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Soc. Sec. # _____ Date Employed _____

Name of Employer _____ Work Phone _____

Dental Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Medical Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL MEDICAL OR DENTAL INSURANCE? ❑ Yes ❑ No If Yes _____

Financial Responsibility

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Understanding that my insurance is a contract between me and the insurance company, I therefore agree to pay any outstanding differences. If your claim remains unpaid after 30 days, you will be responsible for the remaining balance. Medical laboratory procedures are billed separately by the lab. I agree to be responsible for payment of all services rendered on my or my dependent's behalf. Any account reaching the 60 day delinquency point, regardless of insurance status, will incur a 1 1/2 % interest charge and will be billed to you directly and due immediately. All delinquent accounts will be turned over to an attorney and collection agency. I agree that additional fees, such as collection, bank, attorney, and court fees, will be added to the balance. I further agree that Worcester County, Maryland will remain the jurisdiction for any litigation that shall arise from this contract. Appointment changes/cancellations must be made 24 hours in advance to avoid a service charge of 1/2 the appointment charge. Returned checks are subject to a $35 service charge.

We require x-rays and referral on all patients. Please make sure your dentist has mailed or given you the referral and x-ray prior to your appointment. Patients under the age of 18 MUST have a parent or legal guardian with them for their appointment. I understand I will receive an appointment reminder call prior to my appointment unless I request otherwise.

I certify that I have read the above and agree with all terms and conditions.

X _____

Signature of patient (or parent or legal guardian)

Over Please

Patient Medical History

Please answer the information below to the best of your knowledge, it is dangerous to your health to incorrectly answer these questions.

Age _____

Yes No

1. Are you under medical treatment now? ☐ ☐
2. Have you ever been hospitalized for any surgical operations or serious illnesses within the last 5 years? ☐ ☐
   If yes, please explain _____
   _____
3. Are you taking any medication(s) including non-prescription medicine? ☐ ☐
   List your medication(s) _____
   _____
   Do you premedicate with antibiotic prior to dental visit? ☐ ☐
   Do you take blood thinning agents? ☐ ☐
4. Are you allergic to or had any reactions to the following?
   Local Anesthetics (e.g. Novocaine) ☐ ☐
   Penicillin or other Antibiotics ☐ ☐
   Sulfa Drugs ☐ ☐
   Barbiturates ☐ ☐
   Sedatives ☐ ☐
   Iodine ☐ ☐
   Aspirin ☐ ☐
   Any Metals (e.g. nickel, mercury, etc.) ☐ ☐
   Codeine or Other Narcotics ☐ ☐
   Latex Rubber ☐ ☐
   Egg or Soy ☐ ☐
   Have you or a family member had an adverse reaction to general anesthesia? ☐ ☐
   Other (please list) _____
   _____
5. Do you use tobacco? ☐ ☐
6. How much do you smoke or chew per day?
   _____

Yes No

7. Do you have or have you had any of the following? ☐ ☐
   High Blood Pressure ☐ ☐
   Heart Attack ..... When _____ ☐ ☐
   Heart Trouble/Disease ☐ ☐
   Heart Murmur ☐ ☐
   Heart Pacemaker ☐ ☐
   Low Blood Pressure ☐ ☐
   Stroke ☐ ☐
   Chest Pain ☐ ☐
   Diabetes ☐ ☐
   Kidney Diseases ☐ ☐
   AIDS or HIV Infection ☐ ☐
   Asthma ☐ ☐
   Respiratory Problems ☐ ☐
   Easily Winded ☐ ☐
   Joint Replacement or Implant .... When _____ ☐ ☐
   Hepatitis/Jaundice ☐ ☐
   Liver Disease ☐ ☐
   Stomach Troubles Ulcers ☐ ☐
   Rheumatic/Scarlet Fever ☐ ☐
   Recent Weight Loss ☐ ☐
   Glaucoma ☐ ☐
   Hay Fever/Allergies ☐ ☐
   Tuberculosis ☐ ☐
   Radiation Therapy ..... When _____ ☐ ☐
   History of Osteoporosis or Metastatic Disease Medication ☐ ☐
   Other _____ ☐ ☐
   _____
   _____

Women Only:

a) Are you pregnant or think you may be pregnant? ☐ ☐
b) Are you nursing? ☐ ☐
c) Are you taking oral contraceptives? ☐ ☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____

Signature of patient (or parent or legal guardian)

Doctor's Comments: _____

_____

_____

Signature _____ *Date* _____