# Park Slope Oral & Maxillofacial Surgery

**PATIENT INFORMATION:** **TODAY'S DATE** _____

□ Mr. □ Mrs. □ Ms. □ Dr. **First Name:** _____M.I.___ **Last Name:** _____
Sex: □ M □ F Birth Date:_____ Soc Sec#._____ E-Mail_____
□ Single □ Married □ Divorced □ Widow □ Legally Separated □ Retired □ Student □ Minor □ Other
Home Address:_____ Apt#_____ City_____ State_____ Zip_____
Home Tel.(_____)_____Cell.(_____)_____Work.(_____)_____
Referred By_____ General Dentist_____ Orthodontist_____
Have you or any of your relatives been a patient of our practice? □ Yes □ No □ Don't Know
Emergency Contact _____ Tel. (_____) _____
Personal Payment Type: □ Cash □ Check □ Credit Card
Who will be responsible for your account? □ Self □ Spouse □ Father □ Mother □ Other
Spouse or other guarantor information (If different from above)
Name_____Relation_____S.S#_____Birth Date_____
Street_____City_____State_____Zip_____
Tel. (_____) _____Employer_____ Bus.Tel (_____) _____

PHARMACY NAME: _____ PHARMACY PHONE NUMBER :(____) _____

**PRIMARY DENTAL INSURANCE COMPAN**
Insurance Name_____
Insurance Address_____
Subscribers Name_____
Employer: _____
Relation to Patient □ Self □ Spouse □ Dependent
Group #_____ID#_____
S.S. #_____ Birth Date_____

**SECONDARY DENTAL INSURANCE COMPANY**
Insurance Name_____
Insurance Address_____
Subscribers Name_____
Employer: _____
Relation to Patient □ Self □ Spouse □ Dependent
Group #_____ID#_____
S.S. #_____ Birth Date_____

**DENTAL HEALTH HISTORY:**
Reason for today's office visit _____
Do you have any sores or lumps in or near your mouth? □Yes □No
Have you ever had any difficulty or prolonged bleeding with previous extractions? □Yes □No
Do you smoke? □ Yes □ No If yes, ___packs a day for _____years
Difficulty in opening or closing your mouth □Yes □No
Bleeding Gums □ Yes □ No Dry mouth □Yes □No
Loose teeth or broken filling □ Yes □ No Bad breath □Yes □No
Clicking or popping jaw □ Yes □ No Periodontal treatment □Yes □No
Sensitivity to hot or cold □ Yes □ No Sensitivity to sweet or sour liquids □Yes □No
Grinding teeth □ Yes □ No Frequently biting your lips or cheeks □Yes □No

**HEALTH HISTORY**
Are you in good health? □Yes □ No
Have you had (HVP) Heart valve replacement? □ 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 if so, for what are you being treated? _____
Do you have a prosthetic joint / implant? □Yes □No if so, describe where _____
Have you ever had a blood transfusion? □Yes □No
Are you wearing contact lenses? □Yes □No

**THIS SECTION IS FOR WOMEN ONLY:**

Is there a possibility of pregnancy? ☐ Yes ☐ No If so, expected delivery date_____
Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

**MEDICATIONS**

**(Are you taking or have you taken any of the following:**

☐ Bone Density medications / Bisphosphonates (Aredia, Zometa, Fosomax, Actonel)
☐ Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Bilova)
☐ Herbal Supplements
☐ Sleeping Pills
☐ Anti Depressants / Tranquilizers on a regular basis
☐ Diet Pills
☐ Controlled substance
☐ Other:_____

**ALLERGIES:**

☐ Local Anesthetic (Lidocaine)
☐ Penicillin
☐ Other antibiotics
☐ Sulfa
☐ Tranquilizers/ Sedatives (Valium)
☐ Aspirin
☐ Codeine or other narcotics
☐ Iodine
☐ Metals
☐ Latex
☐ Other medication:_____

**HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING**

☐ ADD/ADHD
☐ Anemia
☐ Angina
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problem
☐ Bronchitis
☐ Cancer
☐ Cardiac Pacemaker
☐ Chemical Dependency
☐ Chemotherapy
☐ Chest Pain
☐ Chronic Fatigue
☐ Circulatory Problems
☐ Contagious diseases
☐ Cortisone Treatment
☐ Diabetes
☐ Difficulty Breathing
☐ Epilepsy
☐ Emphysema
☐ Fainting Episodes
☐ Gallbladder Trouble
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV+ /AIDS
☐ Hay Fever
☐ Kidney Disease
☐ Lung Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ MVP
☐ Radiation Treatment
☐ Respiratory Disease
☐ Scarlet Fever
☐ Skin Conditions
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Problems
☐ TMJ
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ History of Alcohol Abuse
☐ History of Drug Abuse
☐ Mental Health Problems
☐ Other:_____

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I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I certify to the best of my knowledge, the information I have provided on this form is complete and correct. I will not hold my surgeon, or any other member of his/ her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: X _____Date: ____/_____/_____

Dental insurance is intended to cover some, but not all of the cost of your treatment. Most plans include deductibles and co-payments, which must be paid by the patient at the time services, are rendered. I accept responsibility for the entire amount of the bill and agree to pay the unpaid portion that my insurance does not cover.

Signature of patient: **X**_____ Date: _____/_____/_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this notice.

Signature of patient **X** _____ Date: _____/_____/_____

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**Office use only**

HHRB: _____ Date: ____/____/_____ ☐ Dr. Chionchio ☐ Dr. Sengupta