AURORA
ORAL AND MAXILLOFACIAL SURGERY

PATIENT INFORMATION

Date _____

Name_____ Wishes to be called _____

Birthdate_____ Soc Sec#_____

Male☐ Female ☐ Minor☐ Single☐ Married☐

Address_____City, State, Zip _____

Home #_____Cell #_____

Employer_____Work #_____Ext_____

Where do you prefer to receive calls? Home☐ Cell☐ Work☐

E--mail Address_____Referred by _____

My Dentist is _____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____Relationship to patient _____

Birthdate_____Soc Sec #_____

Home Phone_____Cell Phone_____

Address_____City, State, Zip _____

Employer_____Work phone_____Ext_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insurance Company _____

Group # _____

Name of Insured_____

Employer _____

Relationship to Patient _____

Insured DOB _____ Ins ID# _____

Secondary Dental Insurance or Medical PPO

Insurance Company _____

Group # _____

Name of Insured _____

Employer _____

Relationship to Patient _____

Insured DOB _____ Ins ID# _____

All of the above information is correct. I understand that I am responsible for all costs of dental treatment. I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I hereby authorize payment directly to Aurora Dental Specialists of the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that as a HIPPA compliant office, the use of cell phones, electronic devices and/or any recording devices is prohibited while in the operatory rooms and/or recovery rooms.

_____ SIGNATURE OF PATIENT OR GUARDIAN

_____ SIGNATURE OF INSURED AND/OR RESPONSIBLE PARTY

MEDICAL HISTORY

Patient name_____Age_____Birthdate _____

Height_____Weight_____ Are you currently under the care of a physician? Yes_____No_____

If Yes, for what reason? _____

Physician's Name_____Phone_____

Please list all medications that you are taking in the box to the right ⇨ ⇨ ⇨

List of all medications: including over the counter medications; vitamins and supplements:

_____
_____
_____
_____
_____
_____
_____

Have you ever taken prescription drugs for weight loss (i.e. PhenFen or Redux) Yes____ No____

Have you ever taken medications for Osteoporosis (i.e. Fosamax, Aredia,Boniva) Yes____ No____

Are you, or have you ever taken any "Blood Thinners" (i.e. Coumadin, Plavix, Xarelto, Pradaxa) Yes____ No____

Do you currently, or have you had to, take antibiotics before dental treatment? Yes____ No____

ALLERGIES:

Are you allergic (or have had an adverse reaction) to: *Check all that apply*

Penicillin_____ Codeine _____ Local Anesthetic _____ Latex _____ None _____

Other medications or substances: _____

_____

Have you had any unusual or unexplained reactions during a surgical procedure? Yes_____No_____
If yes, please explain

Hearing impaired? Yes_____No _____

Do you have any of the following: (*Please mark Yes or No*)

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery	☐	☐	Asthma	☐	☐	Artificial Joint	☐	☐	Hepatitis (A / B/ C)	☐	☐
Heart Murmur	☐	☐	Shortness of Breath	☐	☐	Dementia/Alzheimer's	☐	☐	Blood Transfusion	☐	☐
Heart pacemaker	☐	☐	Respiratory Ailments	☐	☐	Cancer	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐	Stomach Disorders	☐	☐
Rheumatic Heart Disease	☐	☐	Sinus Trouble	☐	☐	Chemotherapy	☐	☐	Organ Transplant	☐	☐
Congenital Heart Disease	☐	☐	Chronic Cough	☐	☐	Prolonged Bleeding	☐	☐	Glaucoma	☐	☐
Artificial Heart Valve	☐	☐	Thyroid problem	☐	☐	Leukemia	☐	☐	Steroid use	☐	☐
Mitral Valve Prolapse	☐	☐	Kidney problems	☐	☐	Blood Disorder	☐	☐	Arthritis/Rheumatism	☐	☐
High Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐	Hemophilia	☐	☐	Neurological Disorder	☐	☐
Low Blood Pressure	☐	☐	HIV positive/AIDS/ARC	☐	☐	Anemia	☐	☐	Epilepsy	☐	☐
Sleep Disorders	☐	☐	Stroke	☐	☐	GERD	☐	☐	Osteoporosis	☐	☐
Sleep Apnea	☐	☐	Fainting Spells	☐	☐	Removal of Spleen	☐	☐	Botox/Cosmetic Filler	☐	☐
Diabetes	☐	☐	Anorexia/Bulimia	☐	☐	Liver Disease	☐	☐	Substance abuse/Alcoholism	☐	☐

Do you have a condition that is not listed that we should be aware of? If yes please note: _____

DR. COMMENTS: PREMEDICATION REQUIRED ☐

Women:
Are you pregnant?Yes/No Due Date_____
Are you taking contraceptives? Yes/ No
If yes, please note: _____

Do you currently smoke or use the following tobacco products?
Cigarettes_☐__ Cigars_☐__ Pipe_☐__ Chew_☐__ None_☐__
Have you used tobacco products in the past? Yes ☐ No ☐ If yes, how long ago? _____
Have you had any serious illness, hospitalization or accident? Yes_____ No_____
If yes, please explain: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient matter. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify this doctor of any changes in my health or medication.

Patient's Signature_____ **Date** _____

(Signature of parent or guardian if a minor)

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OUR FINANCIAL POLICY

Thank you for choosing Aurora Dental Specialists. Our mission is to deliver the best oral surgery care available.

Patients are expected to pay by cash, check, credit card or CareCredit the day that service is rendered unless specific arrangements have been made.

For those patients who are covered by insurance, we accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payments to our office. Most insurance plans do not cover 100% of the cost of treatment. You are expected to pay your ***estimated portion*** of the charges the day that services are rendered. We will *ESTIMATE* your portion, but until we actually receive payment from the insurance company, ***it is just an estimation***. Insurance benefits quoted may be reduced based on your employer's plan selection and whether we are a participating provider in your plan. You are ultimately responsible for all charges incurred in this office and obtaining information of participation of insurance plans.
For those patients that we are filing with medical PPO insurance, please keep in mind that benefits to be paid will first be applied to your annual deductible and only if they allow medical coverage for wisdom teeth and the position of such teeth. We will assist you in filing with your insurance company, but ultimately the responsibility lies with you.

Please feel free to ask any questions that may remain unanswered either before or after treatment.

I understand and agree to the above financial policy. I acknowledge I have reviewed a copy of this office's notice of privacy practices attached. (HIPPA)

Patient's Signature_____Date _____
(Parent or Guardian of a minor)

For patient's that are over the age of 18 and wish to have any information pertaining to treatment and/or payment information shared with their parent/guardian (whether by phone or in person) please sign here as consent to disclose information to the following names:

Patient's Signature_____Date_____

Name_____ Relationship_____

Name_____ Relationship _____

Name_____ Relationship _____

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