DR. SCOTT E. BULLOCH, D.D.S., M.S.

ORAL-FACIAL & IMPLANT SURGERY

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Medical Doctor _____ (FIRST NAME) _____ (LAST NAME) Referred By _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section) ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

1.10 **Student:** ❑ Full Time ❑ Part Time ❑ Not School Info _____ (SCHOOL NAME) _____ (ADDRESS)

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

❶ PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ S.S. # _____

I.D. # _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ S.S. # _____

I.D. # _____

❷ SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ S.S. # _____

I.D. # _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____ (ADDRESS)

_____ (CITY) _____ (STATE) _____ (ZIP) Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____

Address _____

_____ (CITY) _____ (STATE) _____ (ZIP)

Tel. (_____) _____ S.S. # _____

I.D. # _____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. 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 only and will be considered confidential.

Reason for today's office visit

		Yes	No
99.	Are you in good health? ..... Height ____ Weight ____	❑	❑
100.	Have there been any changes in your general health in the past year?	❑	❑
101.	Are you under the care of a physician? ..... Date of last visit ____	❑	❑
	If so, for what are you being treated? ____		
102.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe ____		
103.	Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ..... *If so, describe where* ____	❑	❑
104.	Do you have a prosthetic joint/implant? *If so, describe where* ____	❑	❑
105.	Have you had a heart valve replacement or vascular graft?	❑	❑

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis, chronic cough?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficult breathing / other lung trouble?			
121	Tuberculosis?			
122	Emphysema?			
123	Do you smoke?			
124	Do you use chewing tobacco?			
125	Blood transfusion?			
126	Blood disorder such as anemia?			
127	Bruise easily?			
128	Bleeding tendency / abnormal bleed?			
129	Hepatitis, jaundice, or liver disease?			
130	Infectious mononucleosis?			
131	Gallbladder trouble?			
132	Fainting spells?			
133	Convulsions / epilepsy?			
134	Stroke?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .	Yes	No	NOTES
135	Thyroid trouble?			
136	Diabetes?			
137	Low blood sugar?			
138	Kidney trouble?			
139	Are you on dialysis?			
140	Swollen ankles, arthritis or joint disease?			
141	Osteoporosis / Osteopenia?			
142	Osteonecrosis			
143	Stomach ulcers?			
144	Contagious diseases?			
145	Sexually transmitted diseases?			
146	Are you immunosuppressed? possibly from transplant surgery, etc.			
147	Problems with the immune system? possibly from medication / surgery, etc.			
148	Delay in healing?			
149	A tumor or growth?			
150	Radiation therapy / chemotherapy?			
151	Chronic fatigue / night sweats?			
152	Are you on a diet?			
153	A history of drug abuse?			
154	A history of alcohol abuse?			
155	Contact lenses?			
156	Eye disease / glaucoma?			
157	Mental health problems?			
158	A removable dental appliance?			
159	Pain and clicking of jaws when eating?			
160	Malignant hyperthermia?			
161	**IF YOU ARE HAVING SURGERY TODAY,** have you had anything to eat or drink in the last 6 hours?			
160	Who is driving you home?			

Please Note: All numbering is not sequential.

MEDICATION – Are you now taking or have you taken. . .

	Yes	No	NOTES
Any kind of medication, drug, pills?			
Blood thinners (Coumadin, Plavix Aspirin, Vitamin E, Ginko Biloba)?			
Have you ever taken diet pills?			
Any natural product, herbal supplement or homeopathic remedy?			
Any bone density medications / Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)?			
Have you ever taken tranquilizers, sleeping pills, anti depressants, and / or narcotics on a regular basis? If so, please list:			

Please list any medications you are currently taking:

ALLERGIES – Are you allergic to, or had a reaction to. . .

	Yes	No	NOTES
Local anesthetic (numbing med.)?			
Penicillin?			
Other antibiotics?			
Sulfa Drugs?			
Sodium pentothal, Valium, or other tranquilizers?			
Aspirin?			
Codeine or other narcotics?			
Other medications?			
Latex?			
Soy?			
Eggs / Yolk?			
Sulfites?			

Please list any allergies other than drug allergies:

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No *(if so, describe)*

Do you wish to speak to the doctor privately about anything?
❑ Yes ❑ No

Is there a **FAMILY HISTORY** of:

301 **Cancer:**	❑ Yes	❑ No
302 **Diabetes:**	❑ Yes	❑ No
303 **Heart Disease:**	❑ Yes	❑ No
304 **Anesthetic Problems:**	❑ Yes	❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Tel.(_____) _____

Bus. Tel.(_____) _____

IS THIS VISIT RELATED TO AN ACCIDENT?

Automobile:	❑ Yes	❑ No
Work Related:	❑ Yes	❑ No
Other:	❑ Yes	❑ No

Date of Injury _____

Insurance company handling this claim _____

Claim number _____

Name of Attorney / Adjustor _____

Telephone Number (_____) _____

THIS SECTION (401-404) IS FOR WOMEN ONLY, MEN CONTINUE BELOW. WOMEN, CONTINUE BELOW WHEN YOU HAVE COMPLETED THIS SECTION.

Is there a possibility of pregnancy? ❑ Yes ❑ No

Expected delivery date _____

Are you nursing? ❑ Yes ❑ No

Are you taking birth control pills? ❑ Yes ❑ No

Women Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.*

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 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: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. 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 for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

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

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

X X

Date **Signature of patient** *(Parent or Guardian if minor)*

Witness: X

Doctor: X

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 any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X