Dr. Scott E. Bulloch, D.D.S., M.S.

THE ORAL MAXILLOFACIAL & IMPLANT SURGERY CENTER

Our new patient form provides the ability for you to fill out the form and print before you visit our office. Our form uses Adobe PDF technology and in order for it to be filled out properly you must follow these steps.

1. Install the free Adobe Reader
2. Download the New Patient Form to your local computer.
3. Open the form in Adobe Reader
    - It is critical that the form be opened in Adobe Reader due to technical limitations with the built in PDF viewers in web browsers (ie Google Chrome)
4. Once you've completed this form, click the **Print** button to print a copy, then bring with you to the office for your appointment.

We apologize for the technical limitations and hope that the above steps are not too inconvenient. Thank you!

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

Please read and complete the following material. If youhave any questions, please ask for assistance from any of our staff. Thank you for selecting Dr. Scott E. Bulloch for your Oral and Maxillofacial Surgery needs.

Date _____

PATIENT INFORMATION

Patient Name _____ Home Phone _____ Cell _____

Street Address _____

Mailing Address _____ Email _____

City, State, ZIP _____ Social Security Number _____

Birthdate _____ Age ___ Sex: ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Employer _____ City, State, ZIP _____ Phone _____

How did you hear about us? _____ Referred by _____ X-Ray _____

Have any family members been a patient of Dr. Bulloch? __ Who? _____ Relationship _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____ Social Security Number _____

Mailing Address _____ Email _____

City, State, ZIP _____ Home Phone _____ Cell _____

Birthdate _____ Age ___ Sex: ❒ Male ❒ Female ❒ Single ❒ Married ❒ Widowed ❒ Divorced

Employer _____ City, State, ZIP _____ Phone _____

SPOUSE OF RESPONSIBLE PERSON (if applicable)

Name _____ Social Security Number _____ Cell _____

Employer _____ City, State, ZIP _____ Phone _____

PRIMARY INSURANCE COMPANY

Insurance Type: ❒ Dental ❒ Medical

Insurance Provider _____

ID# _____

Group# _____

Subscriber's Name _____

Birth Date _____

Social Security Number _____

Relationship to Patient _____

Employer _____

SECONDARY INSURANCE COMPANY

Insurance Type: ❒ Dental ❒ Medical

Insurance Provider _____

ID# _____

Group# _____

Subscriber's Name _____

Birth Date _____

Social Security Number _____

Relationship to Patient _____

Employer _____

To our patients: Although oral surgeons primarily treat the area 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.

HEALTH HISTORY

Are you in good health? ❒ Yes ❒ No Notes _____ Height _____ Weight _____

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 Date of Last Visit _____

If so, for what are you being treated? _____

Have you had any illness, operation or been hospitalized in the past five years? ❒ Yes ❒ No _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
Damaged Heart Valves?			
High Blood Pressure?			
Low Blood Pressure?			
Chest Pain / Angina?			
Heart Attack(s)?			
Irregular Heart Beat?			
Cardiac Pacemaker?			
Heart Valve Replacement or Vascular Graft?			
Heart Surgery?			
Bronchitis, Chronic Cough?			
Asthma?			
Hay Fever / Sinus Problems?			
Sleep Apnea?			
Diffulct Breathing / Other Lung Trouble?			
Tuberculosis?			
Emphysema?			
Do You Smoke?			
Do You Use Chewing Tobacco?			
Prosthetic Joint / Implant?			
Bleeding Tendency / Abnormal Bleeding?			
Hepatitis, Jaundice, or Liver Disease?			
Fainting Spells?			
Convulsions / Epilepsy?			
Stroke?			
Thyroid Trouble?			
Diabetes?			
Low Blood Sugar?			
Kidney Trouble?			
Swollen Ankles, Arthritis or Joint Disease?			
Osteoporosis / Osteopenia?			
Stomach ulcers?			
Contagious Diseases? If so what kind?			
Are You Immunosuppressed? Problems With Immune System?			
Radiation Therapy / Chemotherapy?			
A History of Drug Abuse?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...	Yes	No	NOTES
A history of Alcohol Abuse?			
Eye Disease / Glaucoma?			
Mental Health Problems?			
Pain and Clicking of Jaws When Eating?			
Malignant Hyperthermia?			

MEDICATION - Are you now taking or have you taken...	Yes	No	NOTES
Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Bilboba)?			
Any Natural Product, Herbal Supplement or Homepathic Remedy?			
Any Bone Density Medications/ Bisphosphonates Now or In The Past? (Aredia, Zometa, Fosamax, Actonel)?			

Please list any medication you are currently taking _____

_____

_____

_____

_____

ALLERGIES - Are you allergic to, or had a reaction to...	Yes	No	NOTES
Local Anesthetic (Numbing Med)?			
Penicillin?			
Other Antibiotics?			
Sodium Pentothal, Valium, or Other Tranquilizers?			
Aspirin?			
Codeine or Other Narcotics?			
Soy?			
Eggs / Yolk?			

Please list any other allergies _____

_____

Is there any condition concerning your health that the Docotor should be told about? ❒ Yes ❒ No (if yes, describe)

_____

_____

Do you wish to speak to the doctor privately about anything?

❒ Yes ❒ No

WOMEN ONLY

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.

_____
Initial

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold Dr. Bulloch, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

_____
Initial

I authorize Dr. Bulloch and/or his staff to perform an oral and/or facial examination. I also authorize the taking of all x-rays and/or pictures required or recommended as a part of this examination or record. I also authorize the release of any information or images acquired in the course of my examination and treatment.

_____
Initial

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

_____
Initial

As a condition of your treatment by this office, financial arrangements must be made in advance. This office does not offer "in house financing", we do, however, offer payment arrangement on approved credit through an independant agengy. Payment and/or financial arrangments must be made for all emergency services, or any services performed without previous financial arrangements.

Signature of Patient (Parent or Guardian if Minor): _____ Date:_____

Signature of Guarantor: _____ Date: _____

Signature of Doctor: _____ Date: _____

Thank you for completing our New Patient Form. Please print this form and bring with you to your appointment. We look forward to meeting with you.

Print