COLUMBIA ORAL & FACIAL SURGERY CENTER
www.ColumbiaOFS.com

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Patient Information (Confidential)

Today's Date _____

NAME _____ **Date of Birth** _____ **Age** _____ **Soc. Sec. #** _____

ADDRESS _____ **City** _____ **State** _____ **Zip** _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex: ☐ M ☐ F

If Student, Name of School/College _____ City _____ State _____ ☐ FT ☐ PT

Patient's Employer _____ Occupation _____

Parent's Name (if patient is a minor) _____

Primary Dentist _____ Orthodontist _____ Physician _____

Whom may we thank for Referring You to our Office? _____

I wish to be contacted in the following manner (check all that apply):

☐ Home Phone _____ ☐ Work Phone _____ ☐ Cell/Other _____

Please Check One: ☐ OK to leave message with detailed information ☐ Leave message with call-back number only

I allow you to give my clinical information to or answer questions from (check all that apply):

☐ Spouse (name) _____ ☐ Parents ☐ Child ☐ Other (specify): _____ ☐ None

Primary Medical & Dental Insurance Information

Policyholder's Name _____ Date of Birth _____ Relationship to Patient _____

Social Security # _____ Work Phone _____ Employer _____ Occupation _____

Dental Ins. Co. _____ Policy/ID # _____ Group # _____

Medical Ins. Co. _____ Policy/ID # _____ Group # _____

Secondary Insurance or Additional Insurance with Different Policyholder

Policyholder's Name _____ Date of Birth _____ Relationship to Patient _____

Social Security # _____ Work Phone _____ Employer _____ Occupation _____

Dental Ins. Co. _____ Policy/ID # _____ Group # _____

Medical Ins. Co. _____ Policy/ID # _____ Group # _____

For Office Staff Use

M/D Ins. Co _____ Plan _____ Date _____

Claim-Address: _____

Phone# _____ Contact _____ Time: _____

In network? Y N Provider# _____ School Status _____

Effective: _____ Calendar/Contract Waiting Period: Y N

Ded. I-I ___o___ Met I-I ___o___ /F-I ___o___ Met F-I ___o___

Max: ____ Used ____ Left ____ Ortho: ____ Used ____ Left ____

Pa ____ Pano _____ Consult _____

(GA-w/_____ N Y _____ %) (N2O-N Y _____ %)

Primary: Y N Denial M/D: Y N COB M/D: Y N

Cert/Auth _____ Lab _____ Ref. M/D _____ If denied _____

Resp. for difference: _____ If Maxed Out _____

Implant _____ MTC: Y N Req. Doc _____

Code	Allowed Amt.	Coverage	Code	Allowed Amt.	Coverage

Total Fee $ _____ Ins. Total Fee: $ _____

CO-PAY $_____ w/LA _____ w/GA _____ w/N20 Initials _____

M/D Ins. Co _____ Plan _____ Date _____

Claim-Address: _____

Phone# _____ Contact _____ Time: _____

In network? Y N Provider# _____ School Status _____

Effective: _____ Calendar/Contract Waiting Period: Y N

Ded. I-I ___o___ Met I-I ___o___ /F-I ___o___ Met F-I ___o___

Max: ____ Used ____ Left ____ Ortho: ____ Used ____ Left ____

Pa ____ Pano _____ Consult _____

(GA-w/_____ N Y _____ %) (N2O-N Y _____ %)

Primary: Y N Denial M/D: Y N COB M/D: Y N

Cert/Auth _____ Lab _____ Ref. M/D _____ If denied _____

Resp. for difference: _____ If Maxed Out _____

Implant _____ MTC: Y N Req. Doc _____

Code	Allowed Amt.	Coverage	Code	Allowed Amt.	Coverage

Total Fee $ _____ Ins. Total Fee: $ _____

CO-PAY $_____ w/LA _____ w/GA _____ w/N20 Initials _____

Patient Medical History

Answer all questions by circling Yes (Y) or No (N)

1. Are you under medical treatment now? . . . . . Y N
   If so, for what condition? _____
2. Has there been any change in your general health in the past year? . . . . . Y N
3. Have you ever had any serious illnesses, operations or hospitalizations? . . . . . Y N
   If yes, please explain _____
4. Are you using any of the following?
   - Antibiotics? . . . . . Y N
   - Anticoagulants (Blood Thinners)? . . . . . Y N
   - Aspirin . . . . . Y N
   - Motrin, Aleve, or Ibuprofen? . . . . . Y N
   - High blood pressure medications? . . . . . Y N
   - Steroids (Cortisone, etc.)? . . . . . Y N
   - Tranquilizers? . . . . . Y N
   - Insulin or oral diabetic drugs? . . . . . Y N
   - Digitalis, inderal, nitroglycerin or other heart medications? . . . . . Y N
   - Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? . . . . . Y N
   - Please list any and all medications, over-the-counter medications, herbal remedies, vitamins or minerals?

     _____

     _____
5. Are you allergic to or have you had a reaction to:
   - Local anesthesia (Novocain, etc.)? . . . . . Y N
   - Penicillin or other antibiotics? . . . . . Y N
   - Sedatives, Barbiturates? . . . . . Y N
   - Sulfa Drugs? . . . . . Y N
   - Iodine? . . . . . Y N
   - Aspirin or Ibuprofen? . . . . . Y N
   - Codeine or other pain killers? . . . . . Y N
   - Latex or Rubber Products? . . . . . Y N
   - Any Metals (Nickel, Mercury, etc.)? . . . . . Y N
   - Other allergies or reactions? . . . . . Y N

     Please, list _____
6. Do you smoke or chew tobacco? . . . . . Y N
   How much per day? _____
7. Women Only:
   - Are you Pregnant, or **is there any chance** you might be Pregnant? . . . . . Y N
   - Are you nursing? . . . . . Y N
   - Are you taking oral contraceptives? . . . . . Y N
8. Do you pre-medicate with antibiotics prior to dental procedures? Y N
9. Do you have or have you ever had:
   - Rheumatic Fever . . . . . Y N
   - Heart Murmur . . . . . Y N
   - Mitral Valve Prolapse . . . . . Y N
   - Joint Replacement or Implant . . . . . Y N
   - Cardiac Pacemaker . . . . . Y N
   - High Blood Pressure . . . . . Y N
   - Heart Attack . . . . . Y N
   - Angina / Chest Pains . . . . . Y N
   - Heart Disease / Trouble . . . . . Y N
   - Easily Winded . . . . . Y N
   - Stroke . . . . . Y N
   - Swollen Ankles . . . . . Y N
   - Low Blood Pressure . . . . . Y N
   - Respiratory Problems / Emphysema . . . . . Y N
   - Asthma . . . . . Y N
   - Hay Fever / Allergies . . . . . Y N
   - Sinus or Nasal Problems . . . . . Y N
   - Liver Disease . . . . . Y N
   - Hepatitis / Jaundice . . . . . Y N
   - Tuberculosis . . . . . Y N
   - Fainting / Seizures . . . . . Y N
   - Epilepsy / Convulsions . . . . . Y N
   - Stomach Troubles / Ulcers . . . . . Y N
   - Thyroid Problem . . . . . Y N
   - Leukemia . . . . . Y N
   - Diabetes . . . . . Y N
   - Kidney Trouble . . . . . Y N
   - Cancer . . . . . Y N
   - Radiation Therapy . . . . . Y N
   - Glaucoma . . . . . Y N
   - Anemia . . . . . Y N
   - Abnormal Bleeding . . . . . Y N
   - Arthritis . . . . . Y N
   - Recent Weight Loss . . . . . Y N
   - Frequently Tired . . . . . Y N
   - Sexually Transmitted Disease . . . . . Y N
   - AIDS or HIV infection . . . . . Y N
10. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? . . . . . Y N
    If yes, Please explain _____
11. Have you or an immediate family member had any problems associated with intravenous anesthesia? . . Y N
12. Do you wish to talk to the doctor privately about anything? . . . . . Y N

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. 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 during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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.

X _____ _____

Signature of patient (or parent if minor) *Date*

Doctor's Comments _____

_____

_____ *Signature* _____ *Date* _____