

Summit Oral Surgery LLC
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1700 E. Bogard Rd. #B-202
Wasilla, AK 99654
907-357-3414 • Fax 907-357-3714

Patient's Name: _____ Today's Date: _____

Sex: _____ Age: _____ Birth Date: _____ Soc. Sec. # _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work / Cell Phone: _____

Physician: _____ Referring Dentist: _____

If a minor who is the responsible party? (it must be the parent that is present)

Name: _____ Birth Date: _____

Primary Insurance

Secondary Insurance

Name of Insurance: _____

Name of cardholder: _____

Address of cardholder: _____
(If different from above)

Birth Date of Employee: _____

Soc. Sec.# of Employee: _____

HEALTH HISTORY

Patient's Name _____

Date _____

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

All responses are kept confidential

- | | |
|--|--|
| <p>1. Are you in good health? Y N</p> <p>2. Has there been any change in your general health in the past year? Y N</p> <p>3. Date of last physical exam _____</p> <p>4. Are you now under a physician's care for a particular problem? Y N</p> <p>5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe _____ Y N</p> <hr/> <p>6. DO YOU HAVE OR HAVE YOU EVER HAD:</p> <p>A. Rheumatic Fever of Rheumatic Heart Disease? Y N</p> <p>B. Congenital Heart Disease? Y N</p> <p>C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N</p> <p>D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing?) Y N</p> <p>E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? Y N</p> <p>F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N</p> <p>G. Liver Disease? (Jaundice, Hepatitis)? Y N</p> <p>H. Kidney Disease? Y N</p> <p>I. Diabetes? Y N</p> <p>J. Thyroid Disease (Goiter?) Y N</p> <p>K. Arthritis? Y N</p> <p>L. Stomach Ulcers or Colitis? Y N</p> <p>M. Glaucoma? Y N</p> <p>N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee?) Y N</p> <p>O. Radiation (X-ray) treatment for Cancer? Y N</p> <p>P. Clicking or popping of jaw joint, pain near ear, Difficulty opening mouth, grind or clench teeth? Y N</p> <p>Q. Sinus or Nasal problems? Y N</p> <p>R. Any disease, drug or transplant operation that Has depressed your immune system? Y N</p> <p>S. HIV, AIDS, or ARC Y N</p> | <p>F. Tranquilizers? Y N</p> <p>G. Insulin or Oral Anti-Diabetic drugs? Y N</p> <p>H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N</p> <p>I. Any regular prescription medicine, pills or drugs If Yes, please list: _____ Y N</p> <hr/> <p>8. Height _____ Weight _____</p> <p>9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ALLERGIC REACTION TO:</p> <p>A. Local Anesthesia (Novocain, etc.?) Y N</p> <p>B. Penicillin or other antibiotics? Y N</p> <p>C. Sedatives, Barbiturates? Y N</p> <p>D. Aspirin Ibuprofen? Y N</p> <p>E. Codeine or other pain killers? Y N</p> <p>F. Latex or Rubber Products? Y N</p> <p>G. Other allergies or reactions? Please list Y N</p> <hr/> <p>10. Do you smoke or chew Tobacco? Y N
How much per day? _____</p> <p>11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N</p> <p>12. Have you had any serious problems associated with any previous dental treatment? Y N</p> <p>13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N</p> <p>14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? Y N</p> <p>15. Do you wish to talk to the doctor privately about anything? Y N</p> <p>16. FEMALES ONLY</p> <p>A. Are you Pregnant, or <u>is there any chance</u> that you might be Pregnant? Y N</p> <p>B. Are you nursing Y N</p> <p>C. Are you using oral contraceptives? Y N</p> |
|--|--|
7. ARE YOU USING ANY OF THE FOLLOWING:
- | | |
|--|-----|
| A. Antibiotics? | Y N |
| B. Anticoagulants (Blood Thinners?) | Y N |
| C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen | Y N |
| D. High Blood Pressure medications? | Y N |
| E. Steroids (Cortisone, etc.?) | Y N |

Patient or Legal Guardian signature _____

FINANCIAL POLICY

Patient Name: _____

The following information is provided for your convenience as well as for our office. We hope to provide you with a complete understanding of our financial policy and answers to questions most frequently asked by our patients including the insurance requirements. This will allow us to adequately facilitate the processing of the cost of your care.

Insurance Account: If you have insurance, we will estimate your deductible and the portion not covered by your insurance which will be due at the time of treatment. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

No Insurance: If you have no insurance, we require full payment the day service is provided.

Account Responsibility: Many people are under the impression that if they have insurance, it is the insurance company which owes the doctor for their services. This is not the case. The insurance contract is between you and the insurance company. Therefore, you are responsible for the charges incurred, regardless of insurance coverage. Any expense incurred collecting delinquent accounts is added to the account balance. This includes, but is not limited to, a 35% collection fee.

Insurance companies use the term "usual and customary" when setting fee limitations on services. The term suggests, but does not necessarily reflect, the average fees charged by doctors in the community. Please be aware that some insurance companies will pay a claim percentage based upon their "usual and customary fees" and not our actual charges.

This office offers and accepts the responsibility of billing the patient's insurance company. However, it is the responsibility of the patient to supply us with complete and correct insurance information. Incorrect or delayed information may result in delayed payment by the insurance company.

I understand a \$50 fee will be assessed for missed surgery appointments without 24-hour notification

Signature

Date