Welcome to Cheyenne Oral and Maxillofacial Surgery Associates, LLC

Patient: (Mr., Mrs., Ms., Dr.) First Name ________________________ M.I. ______ Last Name _______________________
Street _______________________________ City ____________________________________ State ______ Zip _________
Home Tel # (___)__________________ Business Tel # (___)________________ Employer __________________________
Sex: [ ] Male [ ] Female Date of Birth_____________________ Age _____ Social Security # _______________________
Dentist _______________________ Physician ___________________________ Referred by _________________________
Have you or a family member ever been a patient of our practice? [ ] Yes [ ] No If yes whom? _______________________
Today's method of payment [ ] Cash [ ] Check [ ] Credit Card ____
Name of Spouse: ___________________________ Employer ___________________________Tel # (___) ______________
Father ___________________________________ Employer ___________________________Tel # (___) ______________
Mother ___________________________________Employer ___________________________Tel # (___) ______________
Who will be responsible for your account? [ ] Self [ ] Spouse [ ] Father [ ] Mother [ ] Other
Nearest friend not living with you: ____Tel # (___)______________
Nearest relative not living with you: ____Tel # (___)______________

INSURANCE INFORMATION

Patient Student: Full Time [ ] Part Time [ ] Not [ ] School Name ___________________________________
Married [ ] Divorced [ ] Legally Separated [ ] Widow [ ] Single [ ]
Employed: Full Time [ ] Part Time [ ] Retired [ ] Not [ ] Do you belong to a PPO or HMO? Yes[ ] No [ ]

FEES & PAYMENTS

Please read and initial each paragraph and sign below

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. 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 below. ____

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. A 1 ½% finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collection costs, attorney's fees and court costs. ___

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: ____

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name ___________________ **Tel. #. (___)**_____________
Address ____
____
Employer: ____
Insured Party _____________________ **Relation** ______________
Sex [ ] M [ ] F **Date of Birth:** ________________________
Street: ____
City, State, Zip: _______________________________________
Tel # ________________ **S.S./ID #:** ________________________

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name ___________________ **Tel. #. (___)**_____________
Address ____
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Employer: ____
Insured Party _____________________ **Relation** ______________
Sex [ ] M [ ] F **Date of Birth:** ________________________
Street: ____
City, State, Zip: _______________________________________
Tel # ________________ **S.S./ID #:** ________________________

SECONDARY MEDICAL INSURANCE COMPANY

Ins. Co. Name ___________________ **Tel. #. (___)**_____________
Address ____
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Employer: ____
Insured Party _____________________ **Relation** ______________
Sex [ ] M [ ] F **Date of Birth:** ________________________
Street: ____
City, State, Zip: _______________________________________
Tel # ________________ **S.S./ID #:** ________________________

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YOUR 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
Are you in good health? __________________ Height ___________ Weight ____________	[ ]	[ ]
Have there been any changes in your general health in the past year? __________________	[ ]	[ ]
Are you under the care of a physician? _________________ 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? __________	[ ]	[ ]
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?		
If so describe where ____	[ ]	[ ]
Have you had an organ replacement or prosthetic device? ___________________________	[ ]	[ ]
If so, describe where ___________________________________ year __________________	[ ]	[ ]

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…..	YES	NO	NOTES
Rheumatic fever?	[ ]	[ ]	
Damaged heart valves/ Mitral valve prolapse?	[ ]	[ ]	
Heart murmur?	[ ]	[ ]	
High blood pressure?	[ ]	[ ]	
Low blood pressure?	[ ]	[ ]	
Chest pain, angina?	[ ]	[ ]	
Heart attack(s)?	[ ]	[ ]	
Irregular heart beat?	[ ]	[ ]	
Cardiac pacemaker?	[ ]	[ ]	
Heart surgery?	[ ]	[ ]	
Bronchitis, chronic cough?	[ ]	[ ]	
Asthma?	[ ]	[ ]	
Hay fever/Sinus problems?	[ ]	[ ]	
Tuberculosis?	[ ]	[ ]	
Emphysema?	[ ]	[ ]	
Difficult breathing/other lung trouble?	[ ]	[ ]	
Do you smoke?	[ ]	[ ]	
Blood transfusion?	[ ]	[ ]	
Blood disorder such as anemia?	[ ]	[ ]	
Bruise easily?	[ ]	[ ]	
Bleeding tendency (abnormal bleed)?	[ ]	[ ]	
Jaundice, hepatitis or liver disease?	[ ]	[ ]	
Infectious mononucleosis?	[ ]	[ ]	
Gallbladder trouble?	[ ]	[ ]	
Fainting spells?	[ ]	[ ]	
Convulsions, epilepsy?	[ ]	[ ]	

HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO	NOTES
Stroke?	[ ]	[ ]	
Thyroid trouble?	[ ]	[ ]	
Diabetes?	[ ]	[ ]	
Low blood sugar?	[ ]	[ ]	
Kidney trouble?	[ ]	[ ]	
Are you on dialysis?	[ ]	[ ]	
swollen ankles, arthritis or joint disease?	[ ]	[ ]	
Stomach ulcers?	[ ]	[ ]	
Contagious diseases?	[ ]	[ ]	
Sexually transmitted diseases?	[ ]	[ ]	
Do you have any reason to be Immunosuppressed?	[ ]	[ ]	
Delay in healing?	[ ]	[ ]	
A tumor or growth?	[ ]	[ ]	
X-ray treatment/chemotherapy?	[ ]	[ ]	
Chronic fatigue/night sweats?	[ ]	[ ]	
Are you on a diet?	[ ]	[ ]	
A history of drug abuse?	[ ]	[ ]	
A history of alcohol abuse?	[ ]	[ ]	
Contact lenses?	[ ]	[ ]	
Eye disease/glaucoma?	[ ]	[ ]	
Mental health problems	[ ]	[ ]	
A removable dental appliance?	[ ]	[ ]	
Pain & clicking of jaws when eating?	[ ]	[ ]	
Malignant hyperthermia?	[ ]	[ ]	

MEDICATION

ARE YOU NOW TAKING…	YES	NO	NOTES
Any kind of medicine, drugs, or pills?	[ ]	[ ]	
Anticoagulant's (blood thinners)?	[ ]	[ ]	
Tranquilizers?	[ ]	[ ]	

ARE YOU TAKING…	YES	NO	NOTES
Cortisone?	[ ]	[ ]	
Other medications(please list)	[ ]	[ ]	
Aspirin?	[ ]	[ ]	

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO…	YES	NO
Local anesthetics?	[ ]	[ ]
Penicillin?	[ ]	[ ]
Other antibiotics or sulfa?	[ ]	[ ]
Barbiturates, sedatives or sleeping pills?	[ ]	[ ]
Iodine	[ ]	[ ]

ARE YOU ALLERGIC TO OR HAD A REACTION TO…	YES	NO
Asprin?	[ ]	[ ]
Codeine or other narcotics?	[ ]	[ ]
Other medications?	[ ]	[ ]
Allergies other than drug allergies? (please list)	[ ]	[ ]

Is there a family history of: Cancer YES [ ] NO [ ] Diabetes YES [ ] NO [ ] Heart Disease YES [ ] NO [ ]
Anesthetic Problems YES [ ] NO [ ]

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? YES [ ] NO [ ]

WOMEN

	YES	NO	NOTES
Is there a possibility of pregnancy?	[ ]	[ ]	
Estimated delivery date? __/__/__			

	YES	NO	NOTES
Are you nursing?	[ ]	[ ]	
Are you taking birth control pills?	[ ]	[ ]	

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 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: ____ Date: _______________________
(Parent or Guardian if minor)

Reviewed by: ____ Date: _______________________

Date ________________ BP __________ P __________

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