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SOUTHERN ARIZONA
ORAL & MAXILLOFACIAL SURGERY



Date _____

Patient: (Mr., Mrs., Ms., Dr.) Last Name _____ First Name _____ M.I. _____
Sex: Male Female Date of Birth _____ Age _____ Social Security # _____
Street _____ City _____ State _____ Zip _____
Home Tel.# (____) _____ Business Tel. # (____) _____ Ext. ____ Employer _____
Dentist _____ Medical Doctor _____ Referred By _____
Nearest relative not living with you _____ Tel. #(____) _____
Have you ever been a patient of our practice? Yes No Method of Personal Payment: Cash Check Credit Card

Who will be responsible for your account? Self Spouse Father Mother Other _____
(If self, skip to next paragraph)
Name _____ Soc. Sec.#: _____ Home Tel.: (____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ Tel.: (____) _____

INSURANCE INFORMATION

Patient: Student: Full Time Part Time Not School Name/Address _____
Married Divorced Legally Separated Widow Single
Employed: Full Time Part Time Retired Not

PRIMARY DENTAL INSURANCE COMPANY

Employer _____
Bus. Address _____
Bus. Tel.#: _____ Phone:(____) _____
Ins. Co. Name _____
Address _____
Phone:(____) _____
Group#: _____ **Group Name:** _____
Insured Party _____ Relation _____
Sex: M F Date of Birth _____
Street _____
City, State, Zip: _____
Phone: _____ S.S.#: _____
I.D.#: _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____
Bus. Address _____
Bus. Tel.#: _____ Phone:(____) _____
Ins. Co. Name _____
Address _____
Phone:(____) _____
Group#: _____ **Group Name:** _____
Insured Party _____ Relation _____
Sex: M F Date of Birth _____
Street _____
City, State, Zip: _____
Phone: _____ S.S.#: _____
I.D.#: _____

Please list all medications you are currently taking

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:

	Height	Weight	Yes	No
00. Are you in good health?			<input type="radio"/>	<input type="radio"/>
01. Have there been any changes in your general health in the past year?			<input type="radio"/>	<input type="radio"/>
02. Are you under the care of a physician? If so, for what are you being treated?	Date of last visit:		<input type="radio"/>	<input type="radio"/>
03. Have you had any illness, operation or been hospitalized in the past five years?			<input type="radio"/>	<input type="radio"/>
04. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where			<input type="radio"/>	<input type="radio"/>
05. Do you have a prosthetic joint/implant? If so, describe where			<input type="radio"/>	<input type="radio"/>

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....			NOTES		HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....			NOTES
		Yes	No				Yes	No	
06	Rheumatic fever?				32	Stroke?			
07	Damaged heart valves / mitral valve prolapse?				33	Thyroid trouble?			
08	Heart murmur?				34	Diabetes?			
09	High blood pressure?				35	Low blood sugar?			
10	Low blood pressure?				36	Kidney trouble?			
11	Chest pain, angina?				37	Are you on dialysis?			
12	Heart attack(s)?				38	Swollen ankles, arthritis or joint disease?			
13	Irregular heart beat?				39	Stomach ulcers?			
14	Cardiac pacemaker?				40	Contagious diseases?			
15	Heart surgery?				41	Sexually transmitted diseases?			
16	Bronchitis, chronic cough?				42	HIV / AIDS?			
17	Asthma?				43	Problems with the immune system?			
18	Hay fever / Sinus problems?				44	Delay in healing?			
19	Tuberculosis?				45	A tumor or growth?			
20	Emphysema?				46	X-ray treatment / chemotherapy?			
21	Difficult breathing / other lung trouble?				47	Chronic fatigue / night sweats?			
22	Do you smoke? If so, How much?				48	Are you on a diet?			
23	Blood transfusion?				49	A history of drug abuse?			
24	Blood disorder such as anemia?				50	A history of alcohol abuse?			
25	Bruise easily?				51	Contact lenses?			
26	Bleeding tendency (abnormal bleed)?				52	Eye disease / glaucoma?			
27	Jaundice, hepatitis or liver disease?				53	Mental health problems?			
28	Infectious mononucleosis?				54	A removable dental appliance?			
29	Gallbladder trouble?				55	Pain & Clicking of jaws when eating?			
30	Fainting spells?								
31	Convulsions, epilepsy?								

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

Doctor: _____

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
Local anesthetics?				Aspirin?			
Penicillin?				Codeine or other narcotics?			
Other antibiotics?				Other medications?			
Sodium pentothal, valium, or other tranquilizers?				Allergies other than drug allergies (please list)			

WOMEN

	Yes	No	Notes		Yes	No	Notes
Is there a possibility of pregnancy?				Are you nursing?			
Estimated delivery date?				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.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes No

Is there a **family history** of: Cancer Yes No Diabetes Yes No Heart Disease Yes No Anesthetic Problems Yes No

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: _____ Date: _____
(Parent or Guardian if minor)

Fees, Payments and Authorization

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. Please be made aware that you will be responsible for all costs that your insurance does not cover. Payment is expected at the time of service being provided. This may include but not limited to any deductibles, co-insurance and any other services not-covered / paid from your insurance company. It would be a benefit to you to understand your insurance policy prior to the service(s) being provided. You will be responsible for all collection costs, attorneys fees, and court cost.

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.

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.

Witness: _____

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

Doctor: _____