Oral & Maxillofacial Associates of Arizona, PLC
DBA Christensen Oral Surgery
Edward H. Christensen, DDS

Patient Information

Last Name: First: Middle: Nickname:

Home Address: City: State: Zip:

Date of Birth: Sex: Social Security #:

Home Phone #: Cell#:

EMAIL ADDRESS:

Who is your referring Dentist: Phone #:

Pharmacy: Phone #:

Responsible party if patient is under 18 years of age or is disabled

Last Name: First: Middle:

Address: City: State: Zip:

Home Phone #: Cell # :

Date of Birth: Sex: Social Security #:

Do you have legal custody of the patient? Yes No

If no, name of custodian: Phone #:

Medical Information Release Form
(HIPAA) Release Form)

Name: Date of Birth:

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.
This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released.

This *Release of information* will remain in effect until terminated in writing.

Signed: Date:

Witness: Date:

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

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

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If s, describe: Y N

_____

_____

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease: Y N
   - B. Congenital Heart Disease? Y N
   - C. Cardiovascular Disease (*Please Circle*: Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
   - D. Lung Disease (*Please Circle*: Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you Bruise Easily? Y N
   - G. Liver Disease (Jaundice, Hepatitis)? Y N
   - H. Kidney Disease? Y N
   - I. Diabetes? Y N
   - J. Thyroid Disease (Goiter)? Y N
   - K. Arthritis? Y N
   - L. Stomach Ulcers or Colitis? Y N
   - M. Glaucoma? Y N
   - N. Osteoporosis? Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
   - P. Radiation (X-ray) treatment for Cancer? Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
   - R. Sinus or Nasal problems? Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? Y N
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, Prednisone, etc.)? Y N
   - F. Tranquilizers? Y N
   - G. Insulin or Oral Anti-Diabetic drugs? Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates for Osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? Y N
   - J. Have you ever been advised <u>not</u> to take a medication? Y N

     _____

     _____
   - K. Please list any and all medications taken, including Prescription medications, diet drugs, over-the-counter Medications, herbal or holistic remedies, vitamins or Minerals: _____

     _____

     _____

     _____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? Y N
   - B. Penicillin or other antibiotics? Y N
   - C. Sedatives, Barbiturates? Y N
   - D. Aspirin or Ibuprofen? Y N
   - E. Codeine or other pain killers? Y N
   - F. Latex or Rubber products? Y N
   - G. Metal of any kind? Y N
   - H. Chemicals or jewelry (rash or sensitivity)? Y N
   - I. Food products? Y N
   - J. Other allergies or reactions? Please list Y N

     _____

     _____
9. Do you smoke or chew Tobacco? Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with Any previous dental treatment? Y N
12. Have you or an immediate family member had any Problem associated with intravenous anesthesia? Y N
13. Do you have any disease, condition or problem not listed above that you think the doctor should know about? Y N
14. Do you wish to talk to the doctor privately about anything? Y N
15. Have you ever had a bone density scan? Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? Y N
    - B. Are you nursing? Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of truthful and complete Health History to assist my dentist in providing the best care possible. I Have had the opportunity to discuss my Health History with my dentist.

Date | Signature of Person Completing Health History | Doctor's Initials

---

Medical Update: I have read my Health History dated_____ and confirm that it adequately states past and present conditions.

Date | Exceptions or changes | Patient Signature | Doctor's Initials

Oral & Maxillofacial Associates of Arizona, PLC
DBA Christensen Oral Surgery
Edward H. Christensen, DDS

Financial and Insurance Policy Agreement

Financial Policy: All Oral & Maxillofacial Associates of Arizona's fees are established according to services performed and payment is due when services are rendered. Should your account be referred for collections you will incur a 30% collection fee that is based on your unpaid balance.

Insurance Policy: Surgeons at the Oral & Maxillofacial Associates of Arizona (OMA) may or may not be participating providers in your insurance plan. However, we will advise the insured if we are in or out of your network providing you or your beneficiary's surgical care. Every attempt will be made to determine your financial responsibility, however, this is often limited by the information your insurance company will provide to us. The information provided to OMA will be given to you.

Prior to providing elective surgical care OMA will request, verbally or in writing, a determination of benefits for the planned surgical care from your insurance company. Should the information provided by your insurance company be incorrect, financial responsibility will rest with the insured.

Specific policy language may exist in your policy that describes the manner in which multiple procedure surgery is reimbursed. This information is not routinely available to us thus making it the responsibility of the insured to check with their insurance company and provide us with that language so we can more accurately detail the financial obligation of the insured.

I hereby assign all dental and/or medical benefits to which I am entitled, including private insurance and/or other health plans to Oral and Maxillofacial Associates of Arizona. I authorize the release of any dental or medical information necessary to process claims for payment of services. I understand that is my responsibility to make sure that I update all insurance information as changes occur. I understand that insurance is considered a method of reimbursement for the patient, for fees paid to the physician, and is not a substitute of payment. I understand that the account is my responsibility to pay.

I acknowledge that I understand and agree to the Financial and Insurance Policy Agreement as stated above.

_____ _____

Signature of Patient or Insured Date