West Jersey Oral & Maxillofacial Surgeons, P.C.
6 Sand Hill Road, Suite 301
Flemington, NJ 08822

PLEASE PRINT **Date: ___________________**

PATIENT'S LEGAL NAME:
□Mr □Miss □Ms □Mrs □Dr First: ____________________________ Last: ______________________________

Home Address: ____

City: ___________________________________ State: ______________ Zip Code: _____________________

Home Phone: (   ) _______________ Cell Phone: (   ) _______________ Soc Sec #: _________________

Birthdate: ___________________ Age: ________ Gender: □ M □ F Marital Status: □ S □ M □ D □W

Employer: ________________________________ Work Phone: _______________________________________

Emergency Contact: ____

Phone #: _______________________ Relationship to Patient: ____

Pharmacy: ______________________________ Phone #: ____

Address: ____

Who referred you to our Office? : ________________________ Reason for Visit? __________________________

Dentist: _______________________________ Orthodontist: _____________________________

Cardiologist: ______________________ Primary Care Physician: ________________________#:________________

PERSON RESPONSIBLE FOR ACCOUNT: □ Self (Please skip section and continue below) □ Parent □Guardian

Parent/Guardian Name: _________________________________ Birthdate: ________________________

Soc Sec #: _____________________ Address: ____

City: _________________________________ State: _____________________ Zip Code: ____________

Home Phone: (   ) _______________ Cell: (   ) ______________________ Marital Status: □ S □ M □ D □ W

Employer: ____________________________________ Work Phone: (   ) __________________________

Is this visit related to an accident? Automobile: □ Yes □ No
Work related: □ Yes □ No

Date of injury _____________
Insurance company handling this claim ______________________________
Address ____
Claim number _____________________________
Name of adjuster ___________________________
Telephone number _______________________

Patient's Name: ____ **DOB:** ______________

Height: _____________ **Weight:** ________________

HEALTH HISTORY

To our patients: In order to best serve you it is important to disclose and discuss health problems and medication that you may be taking. Although Oral Surgeons primarily treat the area in and around your mouth, having a comprehensive health history assists with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and are confidential.

Have there been any changes in your general health in the past year? □ Yes □No
If yes, please describe: ____

Are you now under a physician's care for a particular problem at this time? □ Yes □No
If yes, why? ____

Have you ever been hospitalized or had a serious illness? □ Yes □No
If yes, why? ____

PATIENT MEDICAL HISTORY

Do you have or have you ever had (check all that apply):

Congenital heart disease, cardiovascular disease? □ Yes □No
(□heart attack □heart murmur □coronary artery disease □chest pain □high blood pressure □stroke □A-fib □ heart surgery □pacemaker □high cholesterol)

Implants placed anywhere in the body □ Yes □No
(□heart valve □ hip □knee □other)?

□Bleeding disorder □anemia □bleeding tendency □blood transfusion □bruise easily? □ Yes □No

□Liver disease (□jaundice □hepatitis A □B □C)? □ Yes □No

□Stomach ulcers □colitis □reflux (GERD)? □ Yes □No

□Osteoporosis □osteopenia? □ Yes □No

□Sleep apnea □snoring? □ Yes □No

□Lung disease? (□asthma □emphysema □COPD □shortness of breath □chest pain □severe coughing) □ Yes □No

□Neurological/psychologic disorder? □ Yes □No
(□Anxiety □Depression □ADD □ADHD □Parkinson's)

□Kidney disease □kidney failure □dialysis? □ Yes □No

Thyroid disease? □ Hyperthyroid □Hypothyroid □ Yes □No

Diabetes □Type I □Type II □ Yes □No

Arthritis? □Rheumatoid □Osteoarthritis □ Yes □No

□Sinus problems □nasal problems? □ Yes □No

□Headache □migraines □head injury? □ Yes □No

TMJ Problems? (□Clicking □popping □pain within the jaw joint □difficulty opening mouth) □ Yes □No

□Cancer □chemotherapy □radiation (head/neck)? □ Yes □No

If so, where? ____, and when was the date of your last treatment? _______________________

Do you have any disease, condition or problem **not listed above** you think the doctor should know about? □ Yes □No
If yes, please explain: ____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? □ Yes □No Relationship ____________________ Cancer? □ Yes □No Relationship ____________________

Heart disease? □ Yes □No Relationship ____________________ Bleeding Problems? □ Yes □No Relationship ____________________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? □ Yes □No

Are you taking birth control pills? □ Yes □No If yes, name of medication: ____

First Name: ________________________ **Last Name:** ______________________________________

PAST SURGERIES (please list):

____

MEDICATIONS

Please list all medications you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

□**NONE**

____ ____

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

ALLERGIES

□ No known drug allergies □ Latex □Penicillin

List other Medication and Food allergies (please include reactions):

____

____

SOCIAL HISTORY

Do you smoke cigarettes or chew tobacco? □ Yes □No If yes, packs/day _________ years_________

Previously smoked but stopped? □ Yes □No If yes, packs/day _________ years_________

Have you ever sought professional care or been hospitalized for:	**Do you use:**
Drug abuse? □ Yes □No	Alcohol? □ Yes □No How often? _________________
Emotions disorders? □ Yes □No	Recreational drugs? □ Yes □No How often? _________________
Alcoholism? □ Yes □No	

DENTAL HISTORY

Have you had any adverse effects from dental treatment? □ Yes □No If yes, please explain? _____________________________

Do you wish to talk to the doctor privately about anything? □ Yes □No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

____ _____________________________________

Signature of patient, parent or guardian **Date**

____ _____________________________________

Printed name of patient, parent or guardian/Relationship **Doctor's Signature**

Health History Update:

Date	Comments	Doctor's Signature
________________	______________________________	_______________________________________
________________	______________________________	_______________________________________

First Name: ______________________ **Last Name:** ______________________

Financial Policy

All fees are to be paid at the time of examination and /or surgical treatment. If payment is not made at the time of our services, you are expected to work out arrangements for this payment. In the event that your account becomes delinquent and it becomes necessary to collect the balance through the services of a collection agency, you will be held responsible for their fees. If an arrangement is made involving your insurance, you may only need to pay a deposit in advance. If your insurance does not pay within 90 days however, the patient must pay and then receive the reimbursement from the insurance company. **There will be a charge of $40.00 for a returned check. All accounts over 90 days may be subjected to a 1.75% Service Charge per month.**

Insurance Information

Do you have insurance? □ Yes □ No

If yes, please complete the information below. Do not use punctuation (i.e. dashes) in ID and Group numbers. Please allow us to make a copy of your Medical and Dental insurance cards upon arrival to assist in processing your insurance claim.

DENTAL INSURANCE:

Insurance Co: ______________________

Address: ______________________

Person's name on Policy: ______________________

Marital Status: □ S □ M □ D □ W **Gender:** □ M □ F

Address (if different from patient):

____

ID#: ____________ **Group#:** ____________

SS#: ______________________

Employer: ______________________

Policyholder's birthdate: ______________________

Relationship to Patient: □ self □ spouse □ parent

MEDICAL INSURANCE:

Insurance Co: ______________________

Address: ______________________

Person's name on Policy: ______________________

Marital Status: □ S □ M □ D □ W **Gender:** □ M □ F

Address (if different from patient):

____

ID#: ____________ **Group#:** ____________

SS#: ______________________

Employer: ______________________

Policyholder's birthdate: ______________________

Relationship to Patient: □ self □ spouse □ parent

SECONDARY DENTAL INSURANCE:

Insurance Co: ______________________

Address: ______________________

Person's name on Policy: ______________________

Marital Status: □ S □ M □ D □ W **Gender:** □ M □ F

Address (if different from patient):

____

ID#: ____________ **Group#:** ____________

SS#: ______________________

Employer: ______________________

Policyholder's birthdate: ______________________

Relationship to Patient: □ self □ spouse □ parent

SECONDARY MEDICAL INSURANCE:

Insurance Co: ______________________

Address: ______________________

Person's name on Policy: ______________________

Marital Status: □ S □ M □ D □ W **Gender:** □ M □ F

Address (if different from patient):

____

ID#: ____________ **Group#:** ____________

SS#: ______________________

Employer: ______________________

Policyholder's birthdate: ______________________

Relationship to Patient: □ self □ spouse □ parent

Please indicate the method of payment for your bill today: ☐ Cash ☐ Check ☐ Visa ☐ Master card ☐ Amex ☐ Discover

Authorization To Release Information

I hereby authorize West Jersey Oral Surgeons, P.C. to provide any insurance co. and consulting health care professionals information concerning health care, advice, treatments or supplies provided the information will be used exclusively for the purpose of evaluation and administering claims for benefits.

______________________ ______________________

Patient or Authorized Guardian's Signature **Date**

First Name: ______________________________ **Last Name:** ____

West Jersey Oral & Maxillofacial Surgeons, P.C.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read and received a copy of this office's Notice of Privacy Practices.

I allow you to give my protected health information to or answer questions from:

Check all that apply:

□ Spouse

□ Parent(s) Please specify name(s): ____

□ Child Please specify name(s): ____

□ Other Please specify name/relationship: __________________________________

□ None (only talk to me)

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

□ Voice Call

□ Text Message

□ Email: ____

O.K. to leave a message with detailed information regarding your diagnosis and treatment:

□ Yes ____________ □ No _____________

Please initial **Please initial**

____

Print Name

____

Patient's (or Legal Guardian's) Signature Date

For Official Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please specify)

____