PATIENT INFORMATION

PATIENT

Date:

LAST NAME | FIRST NAME | M.I | DATE OF BIRTH

ADDRESS | APT NO. | CITY | STATE | ZIP

MARITAL STATUS | HOME PHONE | CELL PHONE | EMAIL | SOC SECURITY NO.

HAVE YOU EVER BEEN A PATIENT OF OUR PRACTICE

HAS A FAMILY MEMBER EVER BEEN A PATIENT OF OUR PRACTICE
IF YES, STATE THE NAME___________________________________

EMPLOYER & ADDRESS | BUSINESS PHONE | OCCUPATION

PREFERABLE METHOD TO CONTACT

SPOUSE, PARENT OR GUARDIAN

LAST NAME | FIRST NAME | M.I | HOME PHONE | CELL PHONE

ADDRESS | APT NO. | CITY | STATE | ZIP

EMPLOYER | OCCUPATION | BUSINESS PHONE

INSURANCE

PATIENT'S HEALTH INSURANCE PROVIDER | GROUP NO. | ID NO. | PHONE NO.

PATIENT'S DENTAL INSURANCE PROVIDER | GROUP NO. | ID NO. | PHONE NO.

OTHER INFORMATION

PATIENT'S DENTIST | PATIENT'S PHYSICIAN | PATIENT REFERRED TO THIS OFFICE BY

I have completed both sides of this form fully and completely. I certify that I am the patient or the duly authorized general agent of the patient authorized to furnish the information requested. I understand that even if I have insurance coverage, I am responsible for payment for any and all services provided. I also understand that I am liable for any and all fees and costs associated with my account or for any account for which I am the responsible party if not paid within 30 days, which includes but not limited to, interest there on at the rate of 12% APR, returned check fee charges of $25 and if turned over to our Attorney and/or Collection Agency, you agree to reimburse us any fees we incur in such collection efforts which may be based on a percentage at a maximum of 37% of the balance owed, and all costs, and expenses if applicable. I authorize Alexandria Oral Surgery, PC and/or its agents to report my account to credit bureaus if my account or any account for which I am the responsible party has an outstanding balance.

PREFERRED METHOD OF PAYMENT:

Date :

Signature

HEALTH HISTORY

Please answer all of the questions by checking Yes or No . All responses are confidential.

Yes No

1 Are you in good health? ....

2 Has there been any change in your general health in the past year? ....

3 Date of last physical exam :

4 Are you now under a physician's care for a particular problem or condition? If so, please describe......................

5 Have you ever had any serious illnesses, operations or hospitalizations? If so, please describe...............................

6 **DO YOU HAVE OR HAVE YOU EVER HAD:**

a. Rheumatic Fever or Rheumatic Heart Disease?.............

b. Congenital Heart Disease? ....

c. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Heart palpitations, Heart Surgery, Pacemaker)? ....

d. Lung Disease (Asthma, Emphysema, Chronic cough, Bronchitis,Pneumonia, Tuberculosis, Shortness of breath, Chest pain or severe coughing)?.......................

e. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment or other Nervous Disorders?....

f. Bleeding Disorder, Anemia, Bleeding Tendency or Blood transfusions? Do you bruise easily?.....................

g. Liver Disease (Jaundice, Hepatitis)? ....

h. Kidney Disease?...

i. Diabetes?...

j. Thyroid Disease (Goiter)?..

k. Arthritis?...

l. Stomach Ulcers or Colitis?...

m.Glaucoma?..

n. Implants placed anywhere in you body (Heart Valve, Pacemaker, Hip, Knee)?..

o. Radiation (X-ray) treatment for Cancer?........................

p. Sinus or Nasal Problems?...

q. Any disease, drug or transplant operation that has depressed your immune system? ....

r. HIV, AIDS, or ARC? ....

7 **ARE YOU USING ANY OF THE FOLLOWING?**

a. Antibiotics?..

b. Anticoagulants (Blood Thinners)?...................................

c. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.....

d. High Blood Pressure medications?.................................

e. Steroids (Cortisone, etc.)?..

f. Tranquilizers?..

g. Insulin or Oral Anti-Diabetic drugs?..............................

h. Digitalis, Inderal, Nitroglycerin or other heart medications?...

i. Any regular prescription medicine, pill or drug? If so, please list below: ....

j. Herbal or Holistic remedies, Vitamins or over-the-counter medications? If so, please list below: ....

8 **ARE YOU ALLERGIC TO or HAVE YOU HAD AN ADVERSE REACTION TO:**

a. Local Anesthesia (Novacaine, etc.)?.....................................

b. Penicillin or other antibiotics? ....

c. Sedatives, Barbiturates? ....

d. Aspirin or Ibuprofen? ....

e. Codeine or other pain killers? ....

f. Latex or Rubber products?...

g. Other allergies, including food allergies? Please list: ....

9 Do you smoke or chew tobacco?...

10 Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that might affect the care we provide you? ....

11 Have you had any serious problems associated with any previous dental treatment? ....

12 Have you or an immediate family member had any problem associated with intravenous anesthesia? ....

13 Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ......

14 Do you wish to speak to the doctor privately about anything?..

15 **FEMALES ONLY**

a. Are you pregnant, or **is there a chance** that you might be pregnant? ....

b Are you nursing?..

c. If you are using Oral Contraceptives, it is important for you to 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 A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY

Date :

DOCTOR'S INITIALS

OR

MEDICAL UPDATE: I HAVE READ MY HEALTH HISTORY DATED _____________ AND CONFIRM THAT IT ACCURATELY STATES PAST AND PRESENT HEALTH CONDITIONS.

Patient Signature

Date :

DOCTOR'S INITIALS

ALEXANDRIA ORAL SURGERY, PC
ORAL AND MAXILLOFACIAL SURGERY
4660 KENMORE AVENUE - SUITE 204
ALEXANDRIA, VA 22304

(703) 370-3012

JEFFREY R. ROTHMAN, DDS
Diplomate- ABOMS

KEVIN BREWER DDS, MD

I understand that, under the Health Insurance Portability & Accountability Act of 1996 "(HIPPA)", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed tot carry out treatment, payment or health care operations. I also understand you are not required to aggre to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

Signature:

Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ______ Initial : ______ Reasons: ______