



Oral and Facial Surgery
Institute of Houston

General Patient Information

Patient Full Name: _____
Date of Birth: _____ Sex: _____ Social Security No.: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Cell Phone Number: _____
Email: _____ Referring Doctor: _____
Emergency Contact: _____ Phone: _____
Full-Time Student: Yes No If yes, name of college: _____

Responsible Party Info/Insurance Subscriber Info: *The family member your insurance is through

Full Name: _____ Date of Birth: _____
Relationship to Patient: _____ Social Security No.: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Cell Phone Number: _____
Employer: _____

Medical Insurance Carrier: _____

Member ID#: _____ Group ID#: _____ Phone#: _____

Dental Insurance Carrier: _____

Member ID#: _____ Group ID#: _____ Phone#: _____

Signature: _____ Date: _____

OFFICE NOTES - Leave Blank- For Office Use Only



Medical History

Name: _____

Height: _____ Weight: _____ Age: _____

ALLERGIES & MEDICATION

Please list all known allergies :

Please list all current medications :

***Please answer all questions correctly and completely. Your answers are for our records only and will be kept confidential.**

- Are you in good health? Yes No
- Has there been any change in your health in the past year? Yes No
- Date of last physical exam: _____

- Are you now under the care of a physician? Yes No
- If yes, for what condition?: _____

Physician's full name : _____

- Have you had any serious illness, operation, or hospitalization? Yes No
- If yes, please explain: _____

Are you taking or have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, or other antiresorptive drugs)?..... Yes No

- Are you pregnant? Yes No
- Are you nursing? Yes No
- Are you taking birth control? Yes No
- Do you wear contact lenses? Yes No

• Do you have any of the following diseases or problems?

- | | |
|--|--|
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Shortness of Breath/Emphysema | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stomach Ulcers/Reflux |
| <input type="checkbox"/> Heart Surgery/Valve Replacement | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arthritis or Painful Joints (Including TMJ) |
| <input type="checkbox"/> Any Other Heart Trouble | <input type="checkbox"/> Asthma or Hay Fever |
| <input type="checkbox"/> Anemia or Other Blood Disorder | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Other Blood Disorder | <input type="checkbox"/> Persistent Cough |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Frequent Mouth Sores | <input type="checkbox"/> Tumor or Cancerous Growth |
| <input type="checkbox"/> Neurologic Disorder or Epilepsy | <input type="checkbox"/> Radiation Treatment or Chemotherapy |
| <input type="checkbox"/> Anxiety or Psychiatric Conditions | <input type="checkbox"/> Persistent Swollen Neck Glands |
| <input type="checkbox"/> Fainting Spells or Seizures | <input type="checkbox"/> Alcohol or Chemical Dependency |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Smoke or Chew Tobacco |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other condition doctor should know |
| <input type="checkbox"/> Prosthetic Joint(s) | |

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

Patient Signature: _____ Date: _____



Privacy Practices

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor to use and disclose my personal information to carry out treatment, payment, and other necessary healthcare operations.

Signature: _____ Date: _____

Fees & Payments

I understand and agree that all fees are the responsibility of the patient and/or responsible party, due and payable within 90 days from the day of service, irrespective and regardless of any insurance claims or other anticipated benefits. Account balances older than 90 days will be subject to interest charges in the amount of 18% per annum, and further subject to collection fees which would accrue should it become necessary to enlist an outside agency for collection services.

• Patient Signature: _____ • Date: _____
(Parent or Guardian, if Minor)

I hereby authorize payment directly to **Oral Facial Surgery Institute, Inc.**, of benefits due me for services provided by him and/or his representatives. I understand that I am financially responsible for the entire cost of services provided regardless of insurance coverage. I hereby authorize the release of any information acquired in the course of my treatment as may be necessary to process my insurance claim.

• Patient Signature: _____ • Date: _____
(Parent or Guardian, if Minor)

Authorization for Release of Information to Family and/or Friends

• Patient Name: _____ • Date of Birth: _____

Oral Facial Surgery Institute, Inc. is authorized to release protected health information about the above-named patient to the entities named below.

- Medical Information
- Results from Tests or X-rays
- Financial Information

• Family/Friend Name: _____ • Phone: _____
• Family/Friend Name: _____ • Phone: _____