

**CONFIDENTIAL  
MEDICAL INFORMATION**

PATIENT NAME: \_\_\_\_\_

SEX : AGE : BIRTHDATE : MARITAL STATUS:  
M/F \_\_\_\_\_ S M W D

SOCIAL SECURITY # \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME # \_\_\_\_\_ WORK # \_\_\_\_\_  
GENERAL DENTIST: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_  
EMPLOYER/SCHOOL: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_

IN CASE OF EMERGENCY  
NAME: \_\_\_\_\_  
HOME # \_\_\_\_\_ WORK # \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ RELATION: \_\_\_\_\_  
SPOUSE/PARENT/GUARDIAN

Last First Middle  
ADDRESS: \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

HOME # \_\_\_\_\_ WORK # \_\_\_\_\_  
EMPLOYER NAME/ ADDRESS \_\_\_\_\_

DENTAL INSURANCE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
MEDICAL INSURANCE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

**List any Allergies to drugs or medicines, Food Allergies (Products) and Latex**

**List any Medicine, natural products, herbal supplements or teas you are taking (including all diet pills)**

**List any previous Hospitalizations/Surgeries**

\_\_\_\_\_

**Circle any conditions that you have had**

Heart Condition  
Heart Murmur  
Mitral Valve Prolapse  
Rheumatic Fever  
Artificial Heart Valve  
Total Knee Replacement  
Total Hip Replacement  
Arterial Grafts  
Other Implant Devices  
Heart Surgery

High Blood Pressure  
Lung disease  
Bronchitis  
Emphysema  
Asthma  
TB  
Liver Problems  
Jaundice  
Hepatitis  
Ulcers  
Stroke  
Nervous Disorders

Kidney Problems  
Bladder Infections  
Diabetes  
Thyroid Disorder  
Sickle Cell Disease  
Anemia  
Transfusions  
Cancer  
Venereal Disease  
Glaucoma  
Bleeding Disorder  
Aids  
Sleep Disorders

- |                          |                          |   |
|--------------------------|--------------------------|---|
| Yes                      | No                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have chest pain?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have shortness of breath?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your ankles swell?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? How much? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a frequent cough?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty breathing through your nose?                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had hives, weakness or difficulty breathing after an injection? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had trouble with a general anesthesia?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you bruise easily?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had prolonged bleeding following surgery?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had radiation (X-ray) treatment?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had chemotherapy?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken cortisone, prednisone, or steroids?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any unlisted health condition your doctor should know?               |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you eaten or drank anything in the past 6 hours?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your general health Good ___ Fair ___ Poor ___                             |

PREGNANT WOMEN	
Yes	No
___	___
___	___
___	___

HEART PATIENT	
Cardiologist's Name	_____
Cardiologist's Phone Number	_____

\_\_\_\_\_  
Physician Name Phone Number

\_\_\_\_\_  
Patient Signature Date

**FINANCIAL RESPONSIBILITY  
NORTHWEST ORAL AND MAXILLO-FACIAL SURGEONS, INC.**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

- **ALL PATIENTS MUST COMPLETE OUR “PATIENT INFORMATION FORM” BEFORE SEEING THE DOCTOR.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS WITH A DRIVERS LICENSE OR STATE ID, VISA/MASTERCARD, DISCOVER, AND AMERICAN EXPRESS. (THERE IS A 25-DOLLAR SERVICE CHARGE ON ALL RETURNED CHECKS.)**
- **OUR OFFICE ALSO HAS A MINIMUM FEE OF \$100.00 TO \$250.00 FOR ALL MISSED APPOINTMENTS.**

**INSURANCE**

With pre-approval from our office staff prior to the date of service, we may accept your estimated insurance co-payment, pending payment by your insurance carrier if your balance is over **\$150.00**. If we accept your insurance co-payment, you are responsible for any estimated amount that is determined by our office to be the portion payable by you. Insurance companies will not guarantee payment on any claim until it is submitted for their review; therefore, upon receipt of payment or a denial of payment from your insurance company, we will reconcile your account for any balance due or credit payable to you. If your insurance company has not paid its portion in full with 30 days, we ask that you contact your insurance company or your employer to help expedite their review and payment on your claim. If your insurance company pays you in error, the check must be forwarded to our office within 7 days. **AFTER 30 DAYS, YOU ARE RESPONSIBLE FOR PAYMENT IN FULL IMMEDIATELY.**

**INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY IN MOST CASES.** (If we are a contracted provider for your insurance company, we will inform you and will handle all charges according to our agreement, as it exists.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual & customary” charges, etc., other than to supply factual information as necessary. A delinquent processing fee will be added to your account, if turned over to a collection agency. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.**

All pathology lab fees are the patient’s responsibility. You will be receiving a separate statement from the lab for this service.

I give my permission to confer with any of my previous physicians who have treated me.

Thank you for understanding our financial policy. Please let us know if you have any questions, or concerns.

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PLEASE INDICATE HOW YOU WILL BE PAYING FOR TODAY’S SERVICES.

[ ] [ ] [ ] [ ] [ ] [ ]  
Cash    Check    Drivers License No.    Birthdate    Credit Card #    Exp. Date

OTHER APPROVED FINANCIALARRANGEMENTS \_\_\_\_\_

**I CLEARLY UNDERSTAND IF IN DEFAULT, I WILL BE RESPONSIBLE FOR ALL LEGAL FEES TO COLLECT MY BILL. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.**

\_\_\_\_\_  
**SIGNATURE OF RESPONSIBLE PARTY: PATIENT/PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_  
**DATE**