DCB ASSOCIATES
Oral Maxillofacial Surgery

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PATIENT INFORMATION

DATE_____

LAST NAME _____ FIRST NAME _____ ❑ MALE / ❑ FEMALE

SOC SEC# _____- _____-_____ ❑ MINOR ❑ SINGLE ❑ MARRIED ❑ DIVORCED

BIRTHDATE _____/_____/_____ AGE_____ PATIENT'S HEIGHT _____ PATIENT'S WEIGHT _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ CELL _____

PATIENT EMPLOYMENT INFORMATION

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

IS PATIENT A STUDENT? ❑ NO ❑ YES ❑ FULL-TIME OR ❑ PART-TIME NAME OF SCHOOL _____

PERSON RESPONSIBLE FOR ACCOUNT _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE POLICY HOLDER'S INFORMATION

NAME _____ ❑ MALE / ❑ FEMALE ❑ SINGLE ❑ MARRIED ❑ DIVORCED

RELATIONSHIP TO PATIENT: ❑ SPOUSE ❑ CHILD ❑ OTHER

BIRTHDATE _____ SOC SEC# _____- _____-_____ EMPLOYER _____

_____

EMPLOYER ADDRESS _____

WORK PHONE _____ OCCUPATION _____

PRIMARY DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME _____

BILLING ADDRESS _____

TELEPHONE _____

POLICY # _____ GROUP # _____

MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY NAME _____

BILLING ADDRESS _____

TELEPHONE _____

POLICY # _____ GROUP# _____

EMERGENCY CONTACT _____ PHONE _____

DO YOU HAVE OR HAVE YOU EVER HAD:

ARTIFICIAL BONE/JOINT	❑ NO	❑ YES	HIGH BLOOD PRESSURE	❑ NO	❑ YES
ABNORMAL HEART CONDITIONS WHAT?	❑ NO	❑ YES	HEPATITIS - A, B, C & NON A - NON B Date of Illness:	❑ NO	❑ YES
HEART ATTACK	❑ NO	❑ YES	GLAUCOMA	❑ NO	❑ YES
MITRAL VALVE PROLAPSE	❑ NO	❑ YES	ASTHMA	❑ NO	❑ YES
HEART MURMUR	❑ NO	❑ YES	DRUG ABUSE	❑ NO	❑ YES
RHEUMATIC FEVER	❑ NO	❑ YES	ALCOHOLISM	❑ NO	❑ YES
STROKE	❑ NO	❑ YES	SEIZURE DISORDER	❑ NO	❑ YES
DIABETES	❑ NO	❑ YES	BRAIN INJURY	❑ NO	❑ YES
CANCER/CHEMOTHERAPY WHEN?	❑ NO	❑ YES	MENTAL/PHYSICAL HANDICAPWHAT?	❑ NO	❑ YES
EMPHYSEMA	❑ NO	❑ YES		❑ NO	❑ YES
SEXUALLY TRANSMITTED DISEASE	❑ NO	❑ YES	ANEMIA: “LOW BLOOD”	❑ NO	❑ YES
HIV/AIDS	❑ NO	❑ YES	KIDNEY/LIVER PROBLEM	❑ NO	❑ YES
EXPOSURE TO SOMEONE WITH AIDS	❑ NO	❑ YES	ABNORMAL BLEEDING/HEMOPHILIA	❑ NO	❑ YES
TUBERCULOSIS	❑ NO	❑ YES	SICKLE CELL TRAIT	❑ NO	❑ YES
THYROID PROBLEMS	❑ NO	❑ YES	ARTHRITIS	❑ NO	❑ YES
TMJ PROBLEMS	❑ NO	❑ YES	OTHER PHYSICAL CONDITIONS	❑ NO	❑ YES
ALLERGIC REACTION (HIVES SWELLING) TO: - PENICILLIN	❑ NO	❑ YES			
- CODEINE	❑ NO	❑ YES	- ERYTHROMYCIN	❑ NO	❑ YES
- ASPIRIN	❑ NO	❑ YES	- SULFA	❑ NO	❑ YES
- LATEX	❑ NO	❑ YES	- DENTAL ANESTHETIC - “NOVOCAIN”	❑ NO	❑ YES
HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? IF YES, FOR WHAT? _____	❑ NO	❑ YES	ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?	❑ NO	❑ YES
ARE YOU TAKING ANY BLOOD THINNERS (COUMADIN, HEPARIN, ASPIRIN, ETC....)?	❑ NO	❑ YES	ARE YOU TAKING ANY MEDICATIONS? IF YES, PLEASE LIST MEDICATIONS	❑ NO	❑ YES
ARE YOU TAKING HERBAL SUPPLEMENTS?	❑ NO	❑ YES	ARE YOU TAKING ANY WEIGHT LOSS MEDICATIONS?	❑ NO	❑ YES
FOR WOMEN: ARE YOU TAKING BIRTH CONTROL PILLS?	❑ NO	❑ YES	FOR WOMEN: ARE YOU PREGNANT? WEEKS # _____	❑ NO	❑ YES
NAME OF YOUR DENTIST TELEPHONE			NAME OF YOUR PHYSICIAN TELEPHONE:		

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I furthermore request payment directly to the undersigned dentist or surgeon, at his election and benefits due for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days for the date of treatment will be assessed a service charge of 1½ % a month.

Signature of patient, parent or guardian (seal) and date _____

Reviewed by: _____