CAROLINAS ORAL & FACIAL SURGERY CENTER
THE DENTAL IMPLANT CENTER

PATIENT INFORMATION

Date _____

Legal Name _____ Birth Date _____ Age _____ *M* ○ / *F* ○

Nickname _____ Marital Status _____ Drivers License No _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ Home Phone _____ Work phone _____ SS# _____

Emergency Contact _____ Phone _____

Employer/School _____ *Part Time* ○ / *Full Time* ○ Spouse name _____

Dentist _____ Physician _____

Whom may we thank for referring you _____

Have you previously been seen/treated by any of our doctors? *Yes* ○ / *No* ○ Approx date _____

Office where seen: *Wilmington* ○ / *Whiteville* ○ / *Jacksonville* ○ Name if different when last seen _____

If patient is a minor and/or college student covered under parent's insurance, please complete:

Parent / Legal Guardian _____ DOB _____

Address _____ SS# _____

INSURANCE INFORMATION

Primary Coverage: *Medical* ○ / *Dental* ○

Ins Co Name _____

Ins Co Phone _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ Birth Date _____ SS# _____

Relationship to Patient _____ Insured's Employer _____

Secondary Coverage: *Medical* ○ / *Dental* ○

Ins Co Name _____

Ins Co Phone _____ Group # (Plan, Local or Policy #) _____

Insured's Name _____ Birth Date _____ SS# _____

Relationship to Patient _____ Insured's Employer _____

BENEFIT ASSIGNMENT / AGREEMENT TO PAY

I hereby authorize my insurance company to make direct payment to the doctor. I understand that I am responsible for all costs of treatment. I further understand that the insurance coverage quoted at the time of service is only an estimate of Usual and Customary Charges and that, after the final insurance payment is made, I will be responsible for the balance.

Adult Patient (Parent or Legal Guardian) _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Carolinas Oral and Facial Surgery Center to release medical information to the patient's insurance carrier and its designates and, in Worker's Compensation cases, to the patient's employer.

Adult Patient (Parent or Legal Guardian) _____ Date _____

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PATIENT'S MEDICAL HISTORY

Name _____ Date _____

Physical Health: *Good* ○ / *Fair* ○ / *Poor* ○ Are you currently under the care of a Physician? *No* ○ / *Yes* ○

If Yes, please explain: _____

Why are you here today? _____

For WOMEN:

On Birth Control? *No* ○ / *Yes* ○ Pregnant? *No* ○ / *Yes* ○ Week # _____ Nursing? *No* ○ / *Yes* ○

Before undergoing any treatment, it is IMPORTANT to let us know if you are PREGNANT or NURSING

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS: (Check all that apply)

- ☐ *Abnormal Bleeding*
- ☐ *Anemia*
- ☐ *Anesthesia Problems (You or a family member*
- ☐ *Arthritis*
- ☐ *Artificial Bones / Joints*
- ☐ *Asthma*
- ☐ *Blood Transfusion*
- ☐ *Cancer*
- ☐ *Chemotherapy*
- ☐ *Colitis*
- ☐ *Diabetes (diet, pills, insulin)*
- ☐ *Difficulty Breathing*
- ☐ *Drug or Alcohol Abuse*
- ☐ *Dry Eyes*
- ☐ *Emphysema*
- ☐ *Epilepsy*
- ☐ *Eye Problems*
- ☐ *Fainting Spells*
- ☐ *Glaucoma*
- ☐ *High Blood Pressure*
- ☐ *Headaches*
- ☐ *Heart Problems- of any kind (surgery, murmurs, pacemaker, etc)*
- ☐ *Hepatitis A B C*
- ☐ *HIV*
- ☐ *Kidney Problems*
- ☐ *Low Blood Pressure*
- ☐ *Migraine Headaches*
- ☐ *Osteoporosis*
- ☐ *Psychiatric Problems*
- ☐ *Radiation Treatment*
- ☐ *Seizures*
- ☐ *Sinus or Nasal Problems*
- ☐ *Sleep Apnea*
- ☐ *Snoring*
- ☐ *Stroke*
- ☐ *Thyroid Problems*
- ☐ *TMJ*
- ☐ *Tobacco Use*
- ☐ *Tuberculosis (TB)*
- ☐ *Ulcers*
- ☐ *Other* _____
- ☐ _____
- ☐ *None*

Please list any serious medical or surgical conditions, hospitalizations or previous injuries:

_____

Please list all medications which you are taking, including NON-PRESCRIPTION or HERBAL medicine:

_____

_____

Circle if you have taken any of the following for osteoporosis: Zometa - Aredia - Boniva - Actonel - Fosamax - Reclast

Are you allergic to any of the following:

- ☐ *Aspirin*
- ☐ *Codeine*
- ☐ *Dental Anesthetics*
- ☐ *Erythromycin*
- ☐ *Food (list)* _____
- ☐ *Latex*
- ☐ *Penicillin*
- ☐ *Sulfa*
- ☐ *Tetracycline*
- ☐ *Other* _____
- ☐ *None*

The information that I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I understand that failure to disclose all past and current medical information and/or medications may adversly affect my surgical outcome.

I authorize the doctor to perform any services deemed necessary during my diagnosis and treatment, with my informed consent .

Adult Patient (Parent or Legal Guardian) _____ Date _____

Doctor's Signature _____