Welcome
Welcome
Welcome

ORAL AND PLASTIC SURGERY
WAYNE OZAKI, M.D., D.D.S., F.A.C.S.

Date _____

PATIENT INFORMATION

1.IP

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ Middle Initial _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ S.S. # _____ Occupation _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ E-Mail _____

Dentist _____ Medical Doctor _____ Referred By _____ Previous patient? ❑ Y ❑ N

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section) (Parent / Guardian Accompanying A Patient Under 26) _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

1.I0

Student: ❑ Full Time ❑ Part Time ..... School Name/Address _____

❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow/Widower _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

• WE ARE NOT AN HMO OR MEDICARE PROVIDER •

PRIMARY DENTAL INSURANCE COMPANY

❶

Employer _____

Insurance Company Name _____

Address _____

1.I1

City _____ State _____ Zip _____

Tel. (_____) _____ Group # _____

I.D. # _____

Subscriber's Name _____

Social Security Number _____

Sex: ❑ M ❑ F Birth Date _____ Relation _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____ Group # _____

I.D. # _____

Subscriber's Name _____

Social Security Number _____

Sex: ❑ M ❑ F Birth Date _____ Relation _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____

SECONDARY DENTAL INSURANCE COMPANY

❷

Employer _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip _____

1.I1

Tel. (_____) _____ Group # _____

I.D. # _____

Subscriber's Name _____

Social Security Number _____

Sex: ❑ M ❑ F Birth Date _____ Relation _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____

Insurance Company Name _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____ Group # _____

I.D. # _____

Subscriber's Name _____

Social Security Number _____

Sex: ❑ M ❑ F Birth Date _____ Relation _____

Address _____

City _____ State _____ Zip _____

Tel. (_____) _____

IF YOU ARE UNABLE TO PROVIDE COMPLETE INSURANCE INFORMATION, YOUR PAYMENT IN FULL IS EXPECTED.

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit _____

		Yes	No
99.	Are you in good health? ..... Height _____ Weight _____	❑	❑
100.	Have there been any changes in your general health in the past year?	❑	❑
101.	Are you under the care of a physician or psychiatrist? ..... Date of last visit _____	❑	❑
	If so, for what are you being treated? _____		
102.	Have you had any illness, operation or been hospitalized in the past?	❑	❑
	If so, describe _____		
103.	Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? ..... *If so, describe where* _____	❑	❑
104.	Do you have a prosthetic joint/implant? ..... *If so, describe where* _____	❑	❑
105.	Have you had a heart valve replacement or vascular graft?	❑	❑

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .		Yes	No	NOTES
106	Rheumatic fever?			
107	Damaged heart valves / mitral valve prolapse?			
108	Heart murmur?			
109	High blood pressure?			
110	Low blood pressure?			
111	Chest pain / angina?			
112	Heart attack(s)?			
113	Irregular heart beat?			
114	Cardiac pacemaker?			
115	Heart surgery?			
116	Bronchitis / chronic cough / pneumonia?			
117	Asthma?			
118	Hay fever / sinus problems?			
119	Snoring / sleep apnea?			
120	Difficult breathing / nasal obstruction?			
121	Tuberculosis?			
122	Emphysema?			
123a	Do you smoke?			
123b	Do you use chewing tobacco?			
124a	Do you consume alcohol daily?			
124b	If so, how much? _____			
125	Blood transfusion?			
126	Blood disorder such as anemia?			
127	Bruise easily?			
128	Bleeding tendency / abnormal bleeding?			
129	Hepatitis, jaundice, or liver disease?			
130	Infectious mononucleosis?			
131	Gallbladder trouble?			
132	Fainting spells?			
133	Convulsions / epilepsy?			

HAVE YOU HAD OR DO YOU CURRENTLY HAVE. . .		Yes	No	NOTES
134	Stroke / blood clots / phlebitis?			
135	Thyroid trouble?			
136	Diabetes?			
137	Low blood sugar?			
138	Kidney trouble?			
139	Are you on dialysis?			
140	Swollen ankles, arthritis or joint disease?			
141	Stomach ulcers?			
142	Contagious diseases?			
143	HIV / AIDS?			
144	Sexually transmitted diseases?			
145	Problems with the immune system?			
146	Delay in healing?			
147	A tumor or growth?			
148a	Radiation therapy / to head and neck?			
148b	Chemotherapy?			
149	Chronic fatigue / night sweats?			
150	Are you on a diet?			
151	A history of drug abuse?			
152	A history of alcohol abuse?			
153	Contact lenses?			
154	Eye disease / glaucoma?			
155	Mental health problems?			
156	A removable dental appliance?			
157	Pain and clicking of jaws when eating?			
158	Malignant hyperthermia?			
159a	**IF YOU ARE HAVING SURGERY TODAY,** and need a ride, who is driving you home? _____			
159b	What is their phone number?			

MEDICATION

Are you now taking. . .		Yes	No	NOTES
201	Any kind of medication, drugs, or pills?			
202	Blood thinners (Coumadin, Plavix, Aspirin, Advil)?			
203	Have you ever taken Phen-Fen?			
204	Tranquilizers?			
205	Any natural product, herbal supplement or homeopathic remedy?			
206	Please list all the medications you are taking:			

WOMEN ONLY (220-223)

		Yes	No	NOTES
220	Is there a possibility of pregnancy?			
221	Expected delivery date ____ / ____ / ____			
222	Are you nursing?			
223	Are you taking birth control pills?			

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

ALLERGIES

Are you allergic to or had a reaction to. . .		Yes	No	NOTES
207	Local anesthetic (numbing med.)?			
207A	General anesthetic?			
208	Antibiotics?			
209	Sulfa Drugs?			
210	Sodium pentothal, Valium, or other tranquilizers?			
211	Aspirin?			
212	Codeine or other narcotics?			
213	Other medications?			
214	Latex?			
215	Soy?			
216	Eggs / Yolk / Milk?			
217	Sulfites?			
218	Penicillin / Amoxicillin?			
219	Please list all allergies you have:			

Is there any condition concerning your health that the Doctor should be told about?
❑ Yes ❑ No *(if so, describe)* _____

Do you wish to speak to the doctor privately about anything?
❑ Yes ❑ No

Is there a **FAMILY HISTORY** of:
301. **Cancer:** ❑ Yes ❑ No
302. **Diabetes:** ❑ Yes ❑ No
303. **Heart Disease:** ❑ Yes ❑ No
304. **Anesthetic Problems:** ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:
Name _____
Home Tel.(_____) _____
Bus. Tel.(_____) _____

IS THIS VISIT RELATED TO AN ACCIDENT?
Automobile: ❑ Yes ❑ No
Work Related: ❑ Yes ❑ No
Other: ❑ Yes ❑ No
Date of Injury _____

Insurance company handling this claim _____
Claim number _____
Name of Attorney / Adjustor _____
Telephone Number (_____) _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Witness: X

X **Date** X **Signature of patient** *(Parent or Guardian if minor)*

Doctor: X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

Any Changes in Health History:

Signature: Date:

Any Changes in Health History:

Signature: Date:

Any Changes in Health History:

Signature: Date:

Any Changes in Health History:

Signature: Date:

Notes: