marlborough
ORAL & MAXILLOFACIAL SURGERY

PATIENT INFORMATION

Patient Name ________________________ (First Name) ______ (M I) ________________________ (Last Name) ☐ M ☐ F

Address ____

____

Telephone: Home ____________________ Cell ____________________ Work ____________________

Date of Birth ____________________ Age ________ Email ____________________

Employer ____________________ Occupation ____________________

Spouse Name (significant other) or Parent(s) ____________________

If not parent(s) – who is the legal guardian? ____________________

PERSON TO CONTACT IN CASE OF EMERGENCY

Name ____________________ Relationship ____________________

Telephone: Home ____________________ Cell ____________________ Work ____________________

DISCLOSURE AUTHORIZATION AND ACKNOWLEDGEMENT OF OUR PRIVACY PRACTICES

DO WE HAVE PERMISSION TO:	Please Circle	
Use the above phone number(s) and/or email address to contact you?	Yes	No
Leave a message on your voicemail?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your condition and care with your spouse, partner, parent, children, or someone else?	Yes	No

If Yes: Name ____________________ Relationship ____________________

My signature below certifies that the information given above is correct. Also, I hereby acknowledge that I have received or have been given the opportunity to receive a copy of this office's Notice of Privacy Practices. I have been given the opportunity to ask any questions regarding this Notice.

X ____
Signature of Patient or Guardian (if under 18)

ACCOUNT RESPONSIBILITY

Marlborough Oral and Maxillofacial Surgery, P.C. will endeavor to obtain full and appropriate reimbursement from your insurance company. We have your authorization for the release of information necessary to process your claim. As with any insurance company there are co-payments for services rendered. These co-payments are due at the time of service. Also, these co-payments are estimates, and after payments are received from your insurance company and after the appropriate adjustments are made, there may be a balance which will be due. We would appreciate you identifying the party who is responsible for the payment of the services rendered. Also, we would appreciate a correct mailing address. If there is more than one party who is responsible, please identify those individuals as well. Thank you for your understanding in this matter.

Print Name ____________________	Print Name ____________________
Signature ____________________	Signature ____________________
Date ____________________	Date ____________________
Mailing Address ____________________	Mailing Address ____________________
(if different from above) ____________________	(if different from above) ____________________

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Patient Name ____

YOU EVER HAD ANY OF THE FOLLOWING?

MEDICAL HISTORY

Heart Disease ☐ Yes ☐ No
Heart Attack ☐ Yes ☐ No
Heart Surgery ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Bleeding Disorder ☐ Yes ☐ No
Prolonged Bleeding ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Asthma- Controlled ☐ Yes ☐ No
Asthma- Childhood Resolved ☐ Yes ☐ No
Asthma- Cold Induced ☐ Yes ☐ No
Asthma- Environmental Induced ☐ Yes ☐ No
Asthma- Exercise Induced ☐ Yes ☐ No
Chronic Bronchitis ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
COPD ☐ Yes ☐ No
Thyroid Disease- Low ☐ Yes ☐ No
Thyroid Disease- High ☐ Yes ☐ No
Gastrointestinal Disease ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No
Heart Burn/GERD ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Radiation Therapy ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No
Kidney Stones ☐ Yes ☐ No
Dialysis ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Hepatitis A ☐ Yes ☐ No
Hepatitis B ☐ Yes ☐ No
Hepatitis C ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Seizure Disorder/Epilepsy ☐ Yes ☐ No
Substance Abuse ☐ Yes ☐ No
Steroid Use ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Rheumatoid Arthritis ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
On CPAP ☐ Yes ☐ No
Pregnant Currently ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Parkinson's Disease ☐ Yes ☐ No
Anxiety/Depression ☐ Yes ☐ No
Bipolar Disorder ☐ Yes ☐ No
Dementia ☐ Yes ☐ No
ADD ☐ Yes ☐ No
ADHD ☐ Yes ☐ No
Autism Spectrum Disorder ☐ Yes ☐ No
Asperger's Syndrome ☐ Yes ☐ No
Artificial Hip Replacement ☐ Yes ☐ No
Artificial Knee Replacement ☐ Yes ☐ No
Malignant Hyperthermia ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No

Have you ever taken any Bone Density Medications/Bisphosphonates? (ie. Fosamax, Actonel, Zolendronate, Prolia) ☐ Yes ☐ No

Female Patients: Are you pregnant? ☐ Yes ☐ No -----> Are you taking birth control pills? ☐ Yes ☐ No

Do you pre-medicate for your dental procedures? ☐ Yes ☐ No -----> Reason ______________________________

Do you smoke or chew tobacco? ☐ Yes ☐ No -----> How much? ______________________________

Other Conditions ____

List Any Surgeries ____

____

List All Medications ____

____

List All Allergies ____

What is your Height? ____________ Weight?____________ To be taken: BP ________ / ________ P ________

Are you currently under the care of a physician? ☐ Yes ☐ No Reason ______________________________

Name of Physician______________________________ Telephone ______________________________

Name of Dentist ______________________________ Referred by ______________________________

Reason for today's office visit? ____

I have answered every question completely and accurately. I will inform my doctor of any change in my health and/or medication.

X ____ Date ______________

Signature of Patient or Guardian (if under 18)