Cherry Orchard
ORAL & IMPLANT SURGERY

Patient Demographic

(PLEASE PRINT)

Today's Date: _____

Patient's Name:

(Mr. / Mrs. / Ms.) _____ _____ _____
First Middle Last

Preferred Name: _____ Date of Birth: _____

Street Address: _____ Apt.#: _____

City: _____ State: _____ ZIP Code: _____

Social Security #: _____ Driver's License #: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Second Cell Phone #: _____

E-Mail Address: _____

Spouse's Name: _____ Phone #: _____

Name of your Dentist: _____

Name & Location of the Pharmacy you use: _____

_____

Name of Responsible Party (if patient is a minor):

(Mr. / Mrs. / Ms.) _____ _____ _____
First Middle Last

Relationship to Patient: _____ Date of Birth: _____

Street Address: _____ Apt. #: _____

City: _____ State: _____ ZIP Code: _____

Social Security #: _____ Driver's License #: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Second Cell Phone #: _____

E-Mail Address: _____

Primary Dental Insurance:

Name of Policy Holder/ Subscriber: _____

Relationship to Patient: Self Parent/Guardian Spouse Other

Policy Holder Date of Birth: _____ Policy Holder Social Security #: _____

Address of Policy Holder (if different from above): _____

_____

Employer or Group through which insurance is acquired: _____

Subscriber ID#: _____ Group #: _____

Insurance Carrier: _____ Phone # for Providers to Verify Benefits: _____

Primary Medical Insurance:

Name of Policy Holder/ Subscriber: _____

Relationship to Patient: Self Parent/Guardian Spouse Other

Policy Holder Date of Birth: _____ Policy Holder Social Security #: _____

Address of Policy Holder (if different from above): _____

_____

Employer or Group through which insurance is acquired: _____

Subscriber ID#: _____ Group #: _____

Insurance Carrier: _____ Phone # for Providers to Verify Benefits: _____

Secondary Dental Insurance:

Name of Policy Holder/ Subscriber: _____

Relationship to Patient: Self Parent/Guardian Spouse Other

Policy Holder Date of Birth: _____ Policy Holder Social Security #: _____

Address of Policy Holder (if different from above): _____

_____

Employer or Group through which insurance is acquired: _____

Subscriber ID#: _____ Group #: _____

Insurance Carrier: _____ Phone # for Providers to Verify Benefits: _____

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Medical History

Your medical history is important to your treatment. Therefore, it is important that you respond to each question honestly and completely.

Name: _____ Nickname: _____ DOB _____/_____/_____ Date: _____/_____/_____
(Last) (First) (MI)

Reason for visit/dental symptoms: _____

Personal Physician: _____ Personal Dentist: _____

Referred by: _____ Age _____ Sex _____ Height _____ Weight _____ lbs.

Please check all appropriate responses and circle when appropriate:

Yes	No		Yes	No	
		NEUROLOGICAL DISORDERS			**HEART DISEASE**
☐	☐	EMOTIONAL DISORDER (DEPRESSION, ANXIETY, ADD, ADHD, BIPOLAR)	☐	☐	HIGH OR LOW BLOOD PRESSURE
☐	☐	VERTIGO, DIZZINESS, NAUSEA, VOMITING	☐	☐	HEART MURMUR OR IRREGULAR HEARTBEAT
☐	☐	BRAIN TUMORS OR SHUNTS	☐	☐	HISTORY OF CHEST PAIN
☐	☐	HISTORY OF STROKE	☐	☐	HEART ATTACK
☐	☐	SEIZURES, EPILEPSY, CONVULSIONS, FAINTING, DIZZINESS	☐	☐	BYPASS HEART SURGERY/HEART STENTS
		HEAD AND NECK	☐	☐	PACEMAKER/DEFIBRILLATOR
☐	☐	GLAUCOMA	☐	☐	CONGENITAL HEART DISEASE
☐	☐	BLURRY OR LOSS OF VISION	☐	☐	ENLARGED HEART
☐	☐	HEARING LOSS OR EAR PROBLEMS	☐	☐	HEART VALVE (MECHANICAL OR PORCINE)
☐	☐	CLICKING, POPPING, OR PAIN WITHIN JAW JOINT OR DIFFICULTY OPENING			**KIDNEYS**
☐	☐	SINUS OR NASAL PROBLEMS	☐	☐	KIDNEY DISEASE
☐	☐	OBSTRUCTIVE SLEEP APNEA/SNORING	☐	☐	EVER REQUIRED DIALYSIS
☐	☐	FREQUENT OR RECURRING MOUTH SORES			**OTHERS**
☐	☐	RADIATION TO THE HEAD AND NECK FOR CANCER	☐	☐	DIABETES (TYPE 1 OR TYPE 2)
☐	☐	THYROID DISEASE	☐	☐	STOMACH ULCERS/GI DISTURBANCES
		BREATHING/LUNGS	☐	☐	ULCERITIVE COLITIS, CROHNS, IBS
☐	☐	BREATHING DIFFICULTY/SHORTNESS OF BREATH	☐	☐	ARTHRITIS
☐	☐	ASTHMA	☐	☐	CHRONIC PAIN OR PERIPHERAL NERVE PAIN
☐	☐	COPD (CHRONIC COUGH, BRONCHITIS, EMPHYSEMA)	☐	☐	HISTORY OF HIV+
☐	☐	RECENT OR RECURRING PNEUMONIA	☐	☐	PROSTHETIC JOINTS (HIP, KNEE, ETC)
☐	☐	REQUIRE SUPPLEMENTAL OXYGEN	☐	☐	HISTORY OF RHEUMATIC FEVER
		LIVER/BLEEDING DISORDERS	☐	☐	DO YOU WEAR CONTACTS?
☐	☐	HEPATITIS A, B, OR C	☐	☐	OSTEOPOROSIS OR OSTEOPENIA
☐	☐	FATTY LIVER, CIRRHOSIS OR LIVER ABNORMALITY	☐	☐	HISTORY OF CANCER: (PLEASE LIST IF YES)
☐	☐	BLEEDING DISORDERS (HEMOPHILIA, VWD, OTHER)			_____
☐	☐	ANEMIA			_____

AUTOIMMUNE DISEASE (PLEASE LIST IF YES)

☐	☐		☐	☐	RADIATION OR CHEMOTHERAPY USED?
			☐	☐	ANY OTHER DISEASE NOT LISTED ABOVE:

_____ _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PLEASE FLIP TO OTHER SIDE):

_____

_____

_____

_____

Yes	No	
		ALLERGIES AND SENSITITIVIES
☐	☐	DRUG ALLERGIES (PLEASE LIST): _____
☐	☐	FOOD ALLERGIES (PLEASE LIST): _____
☐	☐	LATEX
		SURGERIES AND HOSPITILIZATIONS
☐	☐	(PLEASE LIST IF YES)

_____

_____

		SOCIAL HISTORY:
☐	☐	DO YOU SMOKE OR USE TOBACCO PRODUCTS: HOW LONG? _____
☐	☐	ALCOHOL (circle one if yes): SOCIALLY OR HEAVY
☐	☐	RECREATIONAL DRUGS
		OTHER HISTORY
☐	☐	HAVE YOU RECENTLY OR ARE YOU CURRENTLY TAKING PRESCRIPTION PAIN MEDICATION?
☐	☐	ARE YOU TAKING ANY ASPIRIN OR BLOOD THINNER PRODUCTS NOT LISTED ABOVE?
☐	☐	HISTORY OF STEROID USE (PREDNISONE, ETC)?
☐	☐	HISTORY OR CURRENTLY TAKING BISPHOSPHONATES, ANTIANGIOGENIC OR ANTIRESORPTIVE MEDICATIONS: (FOR OSTEOPOROSIS, MULTIPLE MYELOMA, OR CANCERS)/ (EXAMPLES: FOSAMAX, ACTONEL, BONIVA, RECLAST, XGEVA, PROLIA, ZOMETA)
		DENTAL HISTORY
☐	☐	HAVE YOU HAD ANY ADVERSE EFFECTS FROM DENTAL TREATMENT? _____
☐	☐	ARE YOU ALLERGIC OR SENSITIVE TO DENTAL ANESTHETICS? _____
☐	☐	DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANYTHING?
		ANESTHESIA
☐	☐	HAVE YOU EVER HAD GENERAL ANESTHESIA BEFORE?
☐	☐	HAVE YOU HAD ANY ADVERSE EFFECTS OR PROBLEMS WITH GENERAL ANESTHESIA?
☐	☐	ANY FAMILY HISTORY OF ANESTHESIA PROBLEMS?
		FEMALES
☐	☐	CURRENTLY TAKING BIRTH CONTROL?
☐	☐	ARE YOU PREGNANT OR IS THERE A CHANCE YOU MIGHT BE PREGNANT?

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL AND COMPLETE HEALTH HISTORY TO ASSIST MY DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN | DATE

_____ _____

PRINTED NAME OF PATIENT, PARENT, GUARDIAN/RELATIONSHIP | DOCTOR'S SIGNATURE/DATE

HEALTH HISTORY UPDATE

DATE	COMMENTS	DOCTOR'S SIGNATURE
_____	_____	_____
_____	_____	_____

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Insurance Agreement

(Please Initial)

_____ I understand that Cherry Orchard Oral & Implant Surgery will help file my insurance as a courtesy. It is ultimately my responsibility for payment on the balance of this account.

_____ ****BE ADVISED- If your dental coverage is through United Healthcare, we WILL NOT FILE A CLAIM ON YOUR BEHALF if the treatment is extensive in nature or involves wisdom teeth extractions. The patient will be expected to file their own claim. We will provide paper copies of relevant x-rays and surgical notes for the patient to do so. After these are provided to the patient, Cherry Orchard Oral Surgery will have no further involvement in the processing of these claims and the onus will be entirely upon the patient. ***

Cancellation Policy

(Please Initial)

_____ I understand that if my appointment has to be cancelled or changed for any reason it must be done within 24 hours. If I must cancel or reschedule with less than 24-hour notice Cherry Orchard Oral & Implant Surgery will charge me a cancellation or rescheduling fee of $25.00.

Signature of Responsible Party: _____ Date: _____

Authorization for Release of Information

(Please Initial & Sign)

_____ I have received a copy of the Notice of Privacy Practices for the practice Cherry Orchard Oral & Implant Surgery.

Please Print Name: _____

Signature: _____ Date: _____

Name of Patient (if different from above): _____

_____ I authorize the following individuals to have access to my information (covered in the Notice of Privacy Practices mentioned above):

_____

(Name & Relationship)

_____

(Name & Relationship)

_____

(Name & Relationship)

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