The Oral Surgery and Implant Center
Dr. Howard Weitzman, Dr. Gary Kolinsky & Dr. Craig Weitzman

Welcome to our office. We will strive to provide you with the best possible health care. To help us meet your oral healthcare needs, please fill out this form completely. If you have any questions we will be happy to help you.

First Name _____ Age_____

Last Name _____ Height_____

Birth Date _____ Weight_____

Social Security # _____ Sex _____

Address_____ Marital Status S M W D

_____ E-mail address _____

Home # ( ) _____ Occupation _____

Cell # ( ) _____ Spouse's Name _____

Business Name _____ Emergency Contact _____

Business Address _____ Telephone # _____

_____ Dentist _____

Business # ( ) _____ Referred by _____

* I understand that payment is expected on the day of surgery. If the office participates with my insurance plan, I understand that I am responsible for any deductibles, co-pays, non-covered procedures etc. as per the explanation of benefits from my insurance company.

Signature _____ Date _____

Health History for The Oral Surgery and Implant Center
Drs. Howard Weitzman, Gary Kolinsky & Craig Weitzman

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: Y N

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? Y N
   - B. Congenital Heart Disease? Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
   - G. Liver Disease (Jaundice, Hepatitis)? Y N
   - H. Kidney Disease? Y N
   - I. Diabetes? Y N
   - J. Thyroid Disease (Goiter)? Y N
   - K. Arthritis? Y N
   - L. Stomach Ulcers or Colitis? Y N
   - M. Glaucoma? Y N
   - N. Osteoporosis? Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
   - P. Radiation (X-ray) treatment for Cancer? Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
   - R. Sinus or Nasal problems? Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? Y N
   - B. Anticoagulants (Blood Thinners)? Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? Y N
   - F. Tranquilizers? Y N
   - G. Insulin or Oral Anti-Diabetic drugs? Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? Y N
   - J. Have you ever been advised <u>not</u> to take a medication? Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

     _____

     Pharmacy telephone # _____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? Y N
   - B. Penicillin or other antibiotics? Y N
   - C. Sedatives, Barbiturates? Y N
   - D. Aspirin or Ibuprofen? Y N
   - E. Codeine or other pain killers? Y N
   - F. Latex or Rubber products? Y N
   - G. Metal of any kind? Y N
   - H. Chemicals or jewelry (rash or sensitivity)? Y N
   - I. Food products? Y N
   - J. Other allergies or reactions? Please list Y N

     _____

     _____
9. Do you smoke or chew Tobacco? Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N
11. Have you had any serious problems associated with any previous dental treatment? Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
14. Do you wish to talk to the doctor privately about anything? Y N
15. Have you ever had a bone density scan? Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>**is there any chance**</u> you might be Pregnant? Y N
    - B. Are you nursing? Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

_____ Date

_____ Signature of Person Completing Health History

_____ Doctor's Initials

Office Policies and Financial Information

If patient is a minor, who is responsible for payment of fees?
_____ Relationship to the patient? _____
Social Security # _____ Date of Birth _____
Address _____
_____

We accept the following methods of payment. Please indicate your preference:

____ Cash ____ Check ____ MC/Visa ____ AE/Discover

For your information, we accept the following insurance plans. If you have one of these plans please specify by indicating below:

__Aetna DMO (referral required) __ Aetna PPO __Cigna Dental Health
__Cigna PPO __Delta Dental __Dentemax __ DHA Assurant
__Empire PPO __Empire /Dentall (referral required)
__Guardian Dentalguard Preferred __Healthplex Capitation Plan (referral)
__Metlife PDP __Oxford Pemium or Enhanced Dental Plan (reduced fee)
__Principal __United Concordia __United Healthcare (dental)

Insured Subscriber's Name_____
Date of Birth _____
Insurance ID #_____

***Insurance benefits vary according to your individual plan, therefore a determination of payment can not be established until an explanation of benefits is received.**

Our office policy is that we accept these plans only if you have the claim form completed at the time services are rendered and we can confirm your coverage. You are responsible for any remaining balance not covered by your insurance company, for example, lapse in coverage, deductibles, co-payments, non-covered procedures or exceeding yearly maximum allowance. **All co-payments and deductibles are due at the time of service. If there is an additional balance after submitting your claim you will be billed after receiving the explanation of benefits from your insurance company.**

I have read and understand the above office policies and agree to those terms. Signature_____ Date_____