Monesmith & Wood Oral & Maxillofacial Surgery, P.C.

Patient Information
(please print and sign at the bottom)

Mr. Mrs. Ms. Miss _____
First MI Last Nickname

Address:_____ City/State:_____ Zip:_____

Home Tel Number:_____ Work Tel Number:_____ Cell Tel Number:_____

Date of Birth ___ / ___ / ___ Age_____ Sex: ☐ Male ☐ Female

Soc. Sec. #: _____ Employer:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Spouse:_____ SS#_____

Name of your Dentist:_____ Physician:_____ Orthodontist:_____

Who referred you to our office? ☐ Dentist ☐ Physician ☐ Orthodontist ☐ Friend_____ ☐ Other_____

If patient is a full time student, name of school:_____

Emergency contact:_____ Daytime Telephone Number:_____

Relationship to patient:_____

Permission to release my healthcare information to the following person(s) if necessary (i.e., spouse ,son, daughter, etc.)

_____

Is someone other than the patient responsible for this account? ☐ Yes ☐ No If yes, please complete the following information:

Name:_____ DOB:___ / ___ / ___ SSN #:_____ Home Phone:_____

Address:_____ City/State:_____ Zip:_____

Relationship to patient:_____ Occupation:_____ Work Phone:_____

DENTAL

Insurance Coverage Information

If there is additional insurance coverage, please use other side of form.

☐ Copy of card

Primary Dental Insurance

Name of insurance company:_____

Insured Name:_____ DOB ___ / ___ / ___ Insured Daytime Phone:_____

Insured Soc. Sec. #:_____ Plan ID (if other than SS#):_____

Relationship to patient:_____ Group/Account #:_____

Insurance Co. Address:_____ Employer Name:_____

_____

MEDICAL

If there is additional insurance coverage, please use other side of form.

☐ Copy of card

Primary Medical Insurance

Name of insurance company:_____

Insured Name:_____ DOB ___ / ___ / ___ Insured Daytime Phone:_____

Insured Soc. Sec. #:_____ Plan ID (if other than SS#):_____

Relationship to patient:_____ Group/Account #:_____

Insurance Co. Address:_____ Employer Name:_____

_____

Preferred Pharmacy _____ **Phone #:**_____

I understand in signing this statement that I am financially responsible for all fees incurred on my behalf, or this dependent. I agree to be responsible for all fees incurred, including any costs for collection, if necessary, including: attorney fees, court costs, collection costs, consideration for assignment, litigation expenses, or any other incidental expenses incurred by this office or our assignee(s). I authorize the release of healthcare information related to claims processing, and direct any benefits payable to me to be paid directly to the provider. I understand that Drs. Monesmith and Wood will file my insurance claim as a courtesy only and it is my responsibility to check with my insurance company concerning the benefits available to me, preferred provider status, and payment of claims.

Signed: _____ Date: _____

Patient Signature (If the patient is a minor, parent or guardian please sign)

Print name: _____

Medical History

(please mark yes or no for each question)

Patient Name: _____
First MI Last Nickname

Reason for today's office visit: _____

	Yes	No	Notes
Are you in good health?			
Height _____ Weight _____ Age _____			
Have there been any changes in your general health in the past year?			
Are you under the care of physician? If yes, date of last visit _____ For what are you being treated?			
Have you had any serious illness, operation or been hospitalized? If yes, please explain:			
Are you allergic to anything (such as latex, tape, antiobiotics, pain medications)? If yes - Please list			

Please indicate if you have had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart disease				Anemia			
Chest pains				Bleeding problems			
Heart murmur				Stomach ulcers			
Mitral valve prolapse				HIV or AIDS			
Rheumatic fever				Cancer or tumors			
High blood pressure				Radiation treatment			
Artificial heart valve				Chemotherapy			
Pacemaker				Hepatitis or jaundice			
Stroke				Diabetes			
Glaucoma				Thyroid disease			
Fainting spells				Kidney disease			
Asthma				Arthritis			
Lung disease				Artificial joints			
Tuberculosis				Seizures (epilepsy)			
Hay fever/sinusitis				Swollen ankles			
Shortness of breath				Liver disease			
Snoring or sleep apnea				Alcohol/drug abuse			
Delayed healing				Psychiatric disorder			

	Yes	No	Notes
Do you need to premedicate with antibiotics prior to any dental work or surgery?			
Are you currently taking any drugs or medications? If yes - Please list			
Have you ever had any adverse reaction to an anesthetic? If yes - Please list			
Have you ever had or been treated for clicking or pain in your jaw joint (TMJ)? If yes - Please list			
Have you had any unusual problems with previous dental work? If yes - Please list			
Have you ever been prescribed any of the following drugs: Fosamax, Aredia or Zometa?			
Have you ever been treated for or are you taking medication for osteoporosis or any other condition resulting in loss of bone density?			
Is this visit a result of an accident? If yes - Please list			
Do you smoke, vape or use tobacco products?			
Have you ever taken diet pills (such as Fen-Phen or Redux)?			
Are you taking any herbal medications (such as St. John's Wort)?			
Women: Are you taking birth control pills?			
Are you pregnant?			
Are you nursing?			
Do you have any other conditions or problems we should know about prior to treatment? If yes - Please list			
Do you have any history of family diseases that we should know about? If yes - Please list			

Have you been out of the country in the last 21 days? ❑ Yes ❑ No

I hereby certify that the above information is accurate and complete to the best of my knowledge _____ Date: _____
Patient / Parent or Guardian Signature

Dec 20

Monesmith & Wood Oral and Maxillofacial Surgery, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, have been given and have reviewed a copy of the Monesmith & Wood's Notice of Privacy Practices. I understand that my signature on this form gives my consent for my protected health information to be used for the purposes of : **TREATMENT, PAYMENT, HEALTHCARE OPERATIONS.**

I also acknowledge with this consent, that the office of Dr.'s Monesmith & Wood may call (leaving messages on voice mail, answering machine, or in person) or mail to my home or other alternative location, any healthcare operations such as : **APPOINTMENT REMINDERS; INSURANCE ITEMS; PATIENT STATEMENTS; REQUESTS TO CONTACT THE OFFICE; INSTRUCTIONS, OR OTHER REPLIES AS REQUESTED BY THE PATIENT.**

I have the right to revoke this Consent at any time by giving written notice. I understand that revocation of this Consent will not affect any action that was previously taken in reliance of this Consent. If I refuse to sign this Consent, or later revoke it, Dr.'s Monesmith & Wood. may decline to provide treatment to me.

SIGNATURE of Patient/Parent/Guardian PRINTED Name of Patient/Parent/Guardian

_____

Date_____ Witness_____

(The office of Dr.'s Monesmith & Wood reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this office.)