

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Cell Phone# \_\_\_\_\_  
*Last First Middle*

Home Address: \_\_\_\_\_

Patient SS#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
*Street City State Zip*

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Full-Time Student: Y or N Name of School: \_\_\_\_\_

Email address: \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Who is your general dentist? Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Who is your physician? Name: \_\_\_\_\_ Phone# \_\_\_\_\_

What is your pharmacy? Name: \_\_\_\_\_ Cross Streets: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
*Last First Middle*

Address: \_\_\_\_\_  
*Street City Zip*

Relationship to Patient: \_\_\_\_\_ SS/ID#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group#: \_\_\_\_\_

Employer: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
*Last First Middle*

Relationship to Patient: \_\_\_\_\_ SS/ID# \_\_\_\_\_

Insurance Company: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Last First Middle*

Relationship to Patient \_\_\_\_\_

**Legal Responsible party.** If a patient is a minor or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

**Patient's Signature/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

### Health Questionnaire

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please Circle Yes or No.**

1. Has there been any change in your health within the last year? . . . . . Yes No  
 If yes please explain: \_\_\_\_\_
2. Are you now under the care of a physician? . . . . . Yes No
3. Have you ever had or serious illness or operation? . . . . . Yes No
4. Have you been hospitalized in the past five years? . . . . . Yes No  
 If yes please explain: \_\_\_\_\_
5. Do you have, or have you ever had **heart problems**?
  - a. Heart Murmur or heart valve defect . . . . . Yes No
  - b. Rheumatic fever of rheumatic heart disease . . . . . Yes No
  - c. Heart valve replacement . . . . . Yes No
  - d. Congenital heart defect or problems . . . . . Yes No
  - e. Do you have a pacemaker. . . . . Yes No
  - f. Heart problems or heart attack. . . . . Yes No
  - g. High blood pressure. . . . . Yes No
  - h. Low blood pressure. . . . . Yes No
  - i. Irregular or rapid heart beat. . . . . Yes No
  - j. Chest pains. . . . . Yes No
  - k. Shortness of breath. . . . . Yes No
  - l. Swollen ankles or hands. . . . . Yes No
  - m. Artificial joints or prosthetics. . . . . Yes No
6. Do you have, or have you ever had **lung problems**?
  - a. Asthma . . . . . Yes No
  - b. Bronchitis, Tuberculosis, or emphysema. . . . . Yes No
  - c. Other lung problems: \_\_\_\_\_
7. Do you have, or have you ever had **liver problems**?
  - a. Hepatitis or yellow jaundice. . . . . Yes No
  - b. Other liver problems: \_\_\_\_\_
8. Do you have, or have you ever had **kidney problems**?
  - a. Frequent kidney infections. . . . . Yes No
  - b. Frequent urinary tract infections or burning during urination. . . . . Yes No
  - c. Frequent urination or blood in the urine. . . . . Yes No
  - d. Other kidney problems: \_\_\_\_\_
9. Do you have, or have you ever had **blood problems**?
  - a. Anemia. . . . . Yes No
  - b. Bleeding problems. . . . . Yes No
  - c. Bruise easily. . . . . Yes No
10. Do you have, or have you ever had **stomach or intestinal problems**?
  - a. Ulcers, blood in stool, black stools or vomiting blood. . . . . Yes No
  - b. Other stomach or intestinal problems: \_\_\_\_\_
11. Do you have, or have you ever had **endocrine problems**?
  - a. Thyroid problems. . . . . Yes No
  - b. Cortisone or steroid treatments. . . . . Yes No
  - c. Pheochromocytoma. . . . . Yes No
12. Do you smoke? If yes, how much per day? \_\_\_\_\_ Yes No
13. Do you drink alcohol? If yes, how much per day? \_\_\_\_\_ Yes No

East Valley Oral Surgery, P.C.  
 Eric Engel, D.D.S., M.D.  
 3800 West Ray Road ~ Suite 14 ~ Chandler AZ 85226  
 Office: (480)812-8200 Fax: (480) 812-8522

- 14. Have you ever been diagnosed with glaucoma? . . . . . Yes No
- 15. Have you ever experienced tonsillitis? . . . . . Yes No
- 16. Sinus trouble, hay fever, hives, skin rash? . . . . . Yes No
- 17. Fainting spells, seizures, or epilepsy? . . . . . Yes No
- 18. Have you had, or do you have a serious viral illness? . . . . . Yes No
- 19. Hypoglycemia or low blood sugar? . . . . . Yes No
- 20. Diabetes or high blood sugar? . . . . . Yes No
- 21. Arthritis or inflammatory rheumatism? . . . . . Yes No
- 22. Gout? . . . . . Yes No
- 23. Persistent cough or cough up blood? . . . . . Yes No
- 24. Stroke? If yes, when? \_\_\_\_\_ . . . . . Yes No
- 25. Sexually transmitted disease? If yes, when treated? \_\_\_\_\_ . . . . . Yes No
- 26. Do you have an autoimmune disorder? . . . . . Yes No
- 27. Have you had abnormal bleeding or any problems associated with previous tooth removal or oral surgery? . . . . . Yes No
- 28. Have you had any head, neck, or jaw injuries? . . . . . Yes No
- 29. Have you experienced any **problems in your jaw**?
  - a. Clicking. . . . . Yes No
  - b. Pain in the joint, ear, or side of face. . . . . Yes No
  - c. Difficulty opening or closing your mouth, or chewing. . . . . Yes No
- 30. Please list any other diseases, illnesses, or health problems not covered above: \_\_\_\_\_

31. Please circle any of the following drugs you are currently taking:
- |                             |   |                     |
|-----------------------------|---|---------------------|
| Antibiotics or sulfa drugs  | Anticoagulants (blood thinners)                     | Birth control pills |
| Blood pressure medicine     | Cortisone (steroids)                                | Antihistamines      |
| Tranquillizers or sedatives | Insulin or diabetes drugs                           | Antidepressants     |
| Thyroid medication          | Digitalis, Nitroglycerin, or other heart medication |                     |

- 32. List all medications and herbal substances you are currently taking: \_\_\_\_\_

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- 33. List all medications and herbal substances that you have taken within the past month but are not taking now: \_\_\_\_\_
- 34. List all surgeries, x-ray or radiation treatment for a **tumor, growth** or other condition: \_\_\_\_\_

35. Are you allergic to or have you had a bad reaction to any of the following:
- |                      |     |    |                                    |     |    |
|----------------------|-----|----|------------------------------------|-----|----|
| a. Local anesthetics | Yes | No | f. Penicillin or other antibiotics | Yes | No |
| b. Aspirin           | Yes | No | g. Barbiturates or sleeping pills  | Yes | No |
| c. Iodine            | Yes | No | h. Codeine or other narcotics      | Yes | No |
| d. Sulfa drugs       | Yes | No | i. Steroids                        | Yes | No |
| e. Pain medication   | Yes | No | j. Eggs                            | Yes | No |

- 36. Please list all allergies you have: \_\_\_\_\_

- 37. **Women:** Are you or might you be pregnant? . . . . . Yes No

\_\_\_\_\_  
*Signature of Patient, Parent or Guardian* \_\_\_\_\_  
Date

\_\_\_\_\_  
*Signature of doctor* \_\_\_\_\_  
Date

Approved for surgery \_\_\_\_\_ Requires medical or medication consultation \_\_\_\_\_

## PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Date \_\_\_\_\_

**East Valley Oral Surgery  
3800 W. Ray RD #14  
Chandler, AZ 85226**

# East Valley Oral Surgery

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN AND OTHERS

First & Last Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize medical providers and personal of East Valley Oral Surgery, to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I have the right to revoke this authorization in writing, at any time. I understand that such revocation is not effective to the extent that the office has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Relationship to Patient

## PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing East Valley Oral Surgery as your healthcare provider. Please read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. The patient (or patient's guardian) is responsible for payments of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Your insurance is a contract between you and your insurance company. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your coverage. This includes all primary, secondary and any tertiary coverage.
- Co pays; Coinsurance and deductibles are due at the time of service. This charge is an estimate of what your insurance carrier covers. Patients may incur, and are responsible for payment of any additional charges, if applicable. This includes any charges that are not covered by any secondary or tertiary insurance. We expect and encourage that you know your insurance benefits. All out of pocket amounts quoted by East Valley Oral Surgery are estimates. Preapprovals that are received from your insurance company are not a guarantee of payment.
- The patient (or patient's guardian) is required to provide a copy of their insurance card(s) and photo ID.
- Patient statements are sent monthly. Payments for invoices that are billed to the patient are due 30 days from receipt of billing. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement. Any outstanding credits may be applied towards outstanding balances. I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive autodialed, texts, or both, at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, texts, or both, and understand that my consent to such calls. I hereby assign my insurance benefits to be paid directly to East Valley Oral Surgery. I also authorize East Valley Oral Surgery to release any information required to process claims or required in the course of my treatment.
- By signing this document, I state that all information given is accurate and true. I further acknowledge that I have read, understand and agree to the provisions of this Patient Financial Responsibility Form.

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Signature (Patient/Guardian)

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Date