FORT LAUDERDALE
ORAL & MAXILLOFACIAL SURGERY
Dr. Roland Hernandez

General Patient Information

Date: _____

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.

Patient Full Name: _____ Nickname: _____ ☐M ☐F

Birthdate: _____ Age: _____ Soc. Sec.#: _____ Cell Phone #: _____

Work Phone #: _____ Driver's Lic.#: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Physician: _____ Referred By: _____

Nearest Relative Not Living With You: _____ Relative Phone #: _____

Employer: _____ Business Phone #: _____ Ex: _____

Height: _____ Weight: _____ Pharmacy: _____

EMERGENCY CONTACT

Name: _____ Cell Phone #: _____ Work Phone #: _____

RESPONSIBLE FOR ACCOUNT: *If self, skip to the next section*

Full Name: _____ Relationship to Patient: _____

Birthdate: _____ Age: _____ Soc. Sec. #: _____ Cell Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Business Phone #: _____ Ex: _____

INSURANCE INFORMATION:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Primary Dental Insurance Co. Name: _____ Phone #: _____

Insured Name: _____ Relationship to Patient: _____ ☐M ☐F

Birthdate: _____ Soc. Sec.#: _____ ID#: _____ Group #: _____

Primary Medical Insurance Co. Name: _____ Phone #: _____

Insured Name: _____ Relationship to Patient: _____ ☐M ☐F

Birthdate: _____ Soc. Sec.#: _____ ID#: _____ Group #: _____

☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell number if different from above (including area code): _____

_____(initial)

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Medical History

**Health problems or medication can have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

ALLERGIES: Are you allergic or have you had a bad reaction to any of the following?:

- ☐ Local Anesthetic (Numbing Med.)
- ☐ Penicillin
- ☐ Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Sodium Pentothal, Valium or Other Tranquilizers
- ☐ Aspirin
- ☐ Codeine or Other Narcotics
- ☐ Latex
- ☐ Soy
- ☐ Eggs/Yolk
- ☐ Sulfites

Please list all known allergies and reactions to medications : _____

_____

☐ I have no known drug allergies

MEDICATIONS: Are you taking or have you ever taken any of the following?:

- ☐ Blood Thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba)
- ☐ Diet Pills
- ☐ Any bone density medications/Bisphosphonates (Aredia, Zometa, Fosamax, Actonel, Evista, Prolia, Forteo, Evenity)
- ☐ Tranquilizers, Sleeping Pills, Anti-Despressants and/or Narcotics on a Regular Basis

If so, please list: _____

Please list all current medications, including non-prescription, homeopathic and natural remedies:

_____

_____

☐ Currently taking no medications

- Reason for today's office visit: _____
- Are you in good health? ..... ☐ Yes ☐ No
- Has there been any change in your general health in the past year? ..... ☐ Yes ☐ No
- Are you now under the care of a physician? ..... ☐ Yes ☐ No
  If yes, for what condition?: _____
  Date of last visit: _____
- Have you had any serious illnesses, operations or hospitalizations? ..... ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? ..... ☐ Yes ☐ No
  If yes, please explain and describe where: _____
- Do you have a prosthetic joint/implant? ..... ☐ Yes ☐ No
  If yes, please describe where: _____
- Have you had a heart valve replacement or vascular graft? ..... ☐ Yes ☐ No
- Are you on a diet? ..... ☐ Yes ☐ No
- Do you wear contact lenses? ..... ☐ Yes ☐ No
- Do you wear a removable dental appliance? ..... ☐ Yes ☐ No
- Have you had or do you currently have:

☐ Rheumatic Fever
☐ Damaged Heart Valve/Mitral Valve Prolapse
☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chest Pain/Angina
☐ Heart Attack(s)
☐ Irregular Heart Beat
☐ Cardiac Pacemaker
☐ Heart Surgery
☐ Bronchitis or Chronic Cough
☐ Asthma
☐ Hay Fever/Sinus Problems
☐ Snoring/Sleep Apnea
☐ Difficult Breathing
☐ Other Lung Trouble
☐ Tuberculosis
☐ Emphysema
☐ Blood Transfusion
☐ Anemia/Other Blood Disorder
☐ Bruise Easily
☐ Bleeding Tendency
☐ Hepatitis, Jaundice or Liver Disease
☐ Infectious Mononucleosis
☐ Gallbladder Trouble
☐ Fainting Spells
☐ Convulsions/Epilepsy
☐ Stroke
☐ Thyroid Trouble
☐ Diabetes
☐ Low Blood Sugar
☐ On Dialysis
☐ Swollen Ankles, Arthritis or Joint Disease
☐ Osteoporosis/Osteopenia
☐ Osteonecrosis
☐ Contagious Diseases
☐ Sexually Transmitted Diseases
☐ Disease/Drug/Transplant that has Suppressed Immune System
☐ Immune System Trouble/ Problems From Medication, Surgery, Etc.
☐ Delay in Healing
☐ Stomach Ulcers
☐ Kidney Trouble
☐ Eye Disease/Glaucoma
☐ Tumor or Growth
☐ Radiation Therapy or Chemotherapy
☐ Chronic Fatigue or Night Sweats
☐ Mental Health Problems
☐ Pain or Clicking of Jaws When Eating
☐ Malignant Hyperthermia
☐ Smoke or Chew Tobacco
☐ History of Drug Abuse
☐ History of Alcohol Abuse

Notes for any of the above checked: _____

_____

- Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthetic Problems
- Is there any condition concerning your health that the doctor should be told about? ..... ☐ Yes ☐ No
  If yes, please describe: _____
- Do you wish to speak to the doctor privately about anything? ..... ☐ Yes ☐ No

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Medical History (Cont.)

VISIT RELATED TO ACCIDENT: *If No, skip to next section*

- Is this visit related to an accident?: ☐ Yes ☐ No If yes: ☐ Automobile ☐ Work Related ☐ Other
- Date of injury: _____
- Insurance company handling this claim: _____ Claim number: _____
- Name of Attorney or Adjustor: _____ Ph#: _____

WOMEN ONLY:

- Are you pregnant or is there any chance you might be pregnant? ..... ☐ Yes ☐ No
  If yes, expected delivery date: _____
- Are you nursing? ..... ☐ Yes ☐ No
- Are you taking birth control pills? ..... ☐ Yes ☐ No

Please Note: Antibiotics (such as Penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods birth control.

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of the staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature: _____ Reviewed By: _____ Date: _____
(Parent or Legal Guardian If Minor)

Fees & Payments

Arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees and court costs.

Signature: _____ Date: _____
(Parent or Legal Guardian If Minor)

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature: _____ Date: _____
(Parent or Legal Guardian If Minor)

Authorization

I authorize my surgeon and his designated staff to perform an oral and maxillofacial examination, for the purpose of diagnosis and treament planning. Futhermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature: _____ Date: _____
(Parent or Legal Guardian If Minor)

Witness: _____ Doctor: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature: _____ Date: _____
(Parent or Legal Guardian If Minor)