WELCOME TO PETRUNICH ORAL AND MAXILLOFACIAL SURGERY

Patient Information

Name ____

Address____

City_______________________ State ________ Zip ____________

Home #______________________________

Cell # _______________________________

Email Address__________________________

Date of Birth______/_______/_______ Age ________ Sex: Female/Male

SSN#______________________

Pharmacy/Location____

Pharmacy Phone #_______________________

Emergency Contact Name_________________________ Phone #_______________

Financial Responsibility for this account:

Name _____________________________

Address _______________________________________

Phone # ____________________________

IF YOU ARE COVERED BY INSURANCE PLEASE COMPLETE THE BACK OF THIS SHEET

*****Please complete all information in full for policy holder*****

Primary Dental Insurance Company ___________________________

Name of Policy Holder: ____________________________ Date of Birth: ____/____/______

Employer_______________________ I.D. #________________________

SSN#______________________ **(required for some dental plans**) Relation to patient __________

Secondary Dental Insurance Company _____________________

Name of Policy Holder___________________________ Date of Birth_____/____/_______

Employer_________________ ID #_________________________

SSN#_____________________ (**required for some dental plans**) Relation to patient __________

Primary Medical Insurance Company ____________________________

Name of Policy Holder______________________________ Date of Birth____/____/______

Employer______________________ I.D. # _________________________

SSN#______________________ Relation to patient_____________

Secondary Medical Insurance Company ______________________

Name of Policy Holder ____________________________ Date of Birth _____/_____/________

Employer ________________ ID #___________________________

SSN# _______________________ Relation to Patient ______________

PETRUNICH ORAL AND MAXILLOFACIAL SURGERY

Payment for services:

Services today may include a consultation, x-ray, extraction or other treatment that is deemed necessary. **All co-pays, co-insurance, and fee for service are due today.** Please remember that any payment made towards your account is only an estimate or portion of what insurance will not pay. It is not unusual to receive a bill from our office after insurance has paid.

Payment collected today can be made by credit card, debit card, care credit card or cash**. No Personal Checks.**
If a balance goes unpaid we will have to forward it to collections and a fee may be placed on the account balance. This does not include any collection fees. Please call us at any time with questions or concerns.

We also request that you give our office 24-hour notice in the event you need to reschedule your appointment. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a $50.00 no-show fee will be assessed to you.

Patient/Parent Signature ________________________________ Date ____________

Insurance Release:

I certify that I and/or my dependents are covered by insurance and assign all insurance benefits directly to Dr. Petrunich. As the patient/parent/spouse, I understand that I am financially responsible for all charges whether or not paid by insurance and that any quote, authorization or pre-treatment estimate given to the office by an insurance plan does not mean that payment is guaranteed.

Patient/Parent Signature _________________________________ Date____________

PETRUNICH ORAL AND MAXILLOFACIAL SURGERY

Medical Information (HIPAA) Release Form

Patient Name:_______________________________ Date of Birth ____/____/____

Release of Information

Check the box as to who you would like us to release information to i.e. if they call to request your information, to schedule an appointment for you, etc.

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to the person below. List names below:

Spouse____

Child(ren)____

Other____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing. Please sign below if you would like us to release information or not per the checkbox.

*Signature: ____Date____/____/____

Minor Consent:

I am the parent/guardian of the child named above and I authorize Dr. Petrunich and staff to perform necessary dental services including, but not limited to x-rays and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when service is rendered.

[As per Senate Bill 114, when a patient is a minor [15yrs or younger] they have a right to an adult chaperone present if the door is closed during the child's examination/treatment or if the child is sedated. The chaperone may be the child's parent, legal guardian or other caretaker, or an adult staff member.]

*Parent/Guardian Signature ______________________________Date____/____/____

ORAL & MAXILLOFACIAL SURGERY

★ ★ ★ ★ ★

HEALTH HISTORY FORM

Full Name___________________________Date of Birth___________Age_____Height _______Weight______

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

___

___

___

___

5. **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, Coronary Artery Disease, Angina High Blood Pressure, Stroke,Heart Surgery)?........Y N
   - D. Lung Disease (Asthma, Emphysema, Cough, Bronchitis, Pneumonia, Shortness of Breath)?.......Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?...Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, or do you bruise easily?...Y N
   - G. Liver Disease (Jaundice, Hepatitis, Transplant)?...Y N
   - H. Kidney or Renal Disease?....................................Y N
   - I. Diabetes?..Y N
   - J. Thyroid Disease (Goiter)?......................................Y N
   - K. Developmental Disorder (Autism, Asperger)..….....Y N
   - L. Stomach Ulcers or Colitis?....................................Y N
   - M. Depression or Anxiety ?...……………………….....Y N
   - N. Esophageal or Gastric Reflux (GERD)?…….……..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. Obstructive Sleep Apnea or Sleep Disorder?.........Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system?............Y N

6. **FOR WOMEN ONLY**
   - A. Are you Pregnant, or **is there any chance** 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 oral contraceptives.

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, Ibuprofen?...........Y N
   - D. High Blood Pressure medications?........................Y N
   - E. Steroids (Cortisone, etc.)?....................................Y N
   - F. Anti-Depression Medications?……………………..Y N
   - G. ADHD, Hyperactivity Medications?........................Y N
   - H. Insulin or Oral Anti-Diabetic drugs?.......................Y N
   - I. Digitalis, Nitroglycerin, or Heart Medication?..........Y N
   - J. **Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:**

___

___

___

___

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)?.......................Y N
   - B. Penicillin?...Y N
   - C. Antibiotics?...Y N
   - D. Sedatives, Barbiturates?...Y N
   - E. Aspirin or Tylenol?...Y N
   - F. Codeine or other Pain Killers?...............................Y N
   - G. Latex or Rubber Products?....................................Y N
   - H. Other allergies or reactions?.................................Y N

___

___

___

___

DO YOU USE OR HAVE ANY OF THE FOLLOWING:

9. Tobacco (cigarettes, cigars, chewing, pipe)……………..Y N
   Please Circle Above:
10. Recreational Drugs (marijuana, cocaine, ecstasy)?.......Y N
    Please Circle Above:
11. Is there any current or past history of Alcohol, Chemical, or Emotional Disorder that may affect the care we provide you?...Y N
12. Have you had any serious problems associated with any previous dental or medical treatment?...................Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?........Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..Y N

I understand the importance of a truthful Health History to provide the best care possible. I agree that if I have any questions regarding this form or my health, I will discuss it with the treating doctor prior to treatment.

Date________________Signature______________________________________ Doctor's Initial____________