MEDICAL HISTORY FORM

Patient Name:________________________________ Date:______________________

Date of Birth: __________________Sex M/F_____Height: ________ Weight:___________

Address:____

City:___________________________State:______________Zip Code:________________

Home Phone:___________________________Cell Phone:__________________________

Emergency Contact Name:____________________Number:_______________________

Email Address:___________________________General Dentist:____________________

Reason for Appointment:

Dental Insurance Information

Policy Holder:____________________ DOB:____________SS Number:_________________

Policy Number:________________________ Group Number:___________________________

Policy Holder Employer:____

Claims Mailing Address and Phone Number: ______________________________________

Medical Insurance Information

Policy Holder:____________________DOB: __________ SS Number: ____________________

Policy Number:___________________Group Number:_________________________________

Policy Holder Employer:____

Claims Mailing Address and Phone Number:_______________________________________

For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health?...YES or NO
2. Has there been any change in your health in the past year?...............................YES or NO
3. My last physical exam was on ________________________________

4. Are you now under the care of a physician?..YES or NO
   If so, for what condition?
   The name and address of my physician is:

5. Have you had any serious illness, operations or hospitalizations within the past 5 yrs...YES or NO
   If so, for what?

6. Have you had an artificial joint replacement (knee, hip, shoulder, etc.) ......YES or NO
   If Yes, How long ago?

7. Are you taking or have you ever take Bisphosphonates for Osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)?...YES or NO

8. Are you taking any medicine(s) including diet pills, non-prescriptions, and vitamins, homeopathic or natural remedies? ....YES or NO
   if so, please list:

9. Do you have or have you had any of the following disease or problems?
   a. Damaged heart valves, artificial valves or heart murmur ....YES or NO
   b. Rheumatic Heart Disease..YES or NO
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart conditions..YES or NO
      1. Chest pain upon exertion? ....YES or NO
      2. Shortness of breath after mild exercise? ....YES or NO
      3. Do your ankles swell? ....YES or NO
   d. Seasonal Allergies..YES or NO
   e. Sinus trouble..YES or NO
   f. Asthma or hay fever.. YES or NO
   g. Fainting spells or seizures.. YES or NO
   h. Diabetes..YES or NO
   i. Hepatitis, Jaundice or liver disease... YES or NO
   j. Frequent or recurring mouth sores..YES or NO
   k. Thyroid problems...YES or NO
   l. Respiratory problems, emphysema, bronchitis, etc...........................YES or NO
   m. Arthritis or painful, swollen joints including jaw joint(TMJ) .... YES or NO
   n. Osteoporosis..YES or NO
   o. Stomach ulcer or hyperacidity...YES or NO
   p. Kidney trouble..YES or NO
   q. Tuberculosis...YES or NO
   r. Persistent cough or cough that produces blood.............................. YES or NO
   s. Persistent swollen neck glands.. YES or NO
   t. Low blood pressure...YES or NO
   u. Epilepsy or neurological disorder...YES or NO
   v. Cancer...YES or NO
   w. Any disease, drug or transplant operation that has depressed your immune system ....YES or NO

10. Have you had abnormal bleeding? ....YES or NO
    a. Have you ever required a blood transfusion? ....YES or NO
11. Do you have any blood disorder such as anemia? ....YES or NO
12. Have you ever had treatment for a tumor or growth? ....YES or NO
13. Have you had radiation therapy to the head, neck or jaws? ....YES or NO
14. Are you allergic to or have you had a reaction to: ....YES or NO
    a. Local anesthetics.. YES or NO
    b. Penicillin or antibiotics.. YES or NO
    c. Sulfa drugs..YES or NO
    d. Barbiturates or sleeping pills..YES or NO
    e. Aspirin... YES or NO
    f. Iodine...YES or NO
    g. Codeine or other narcotics..YES or NO
    h. Latex or rubber products...YES or NO
    i. Other

15. Have you had any serious trouble associated with previous dental treatment?
    If so, explain:

16. Do you have any other condition or disease you think the doctor should know about?
    If so, explain:

17. Do you smoke or chew
    Tobacco?..YES or NO
    How much?

18. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you?...YES or NO
19. Are you wearing contact lenses?..YES or NO
20. Are you wearing removable dental appliance?...YES or NO
21. Do you wish to talk with the doctor privately about anything?...........................YES or NO

Women

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22. Are you pregnant or trying to become pregnant?..YES or NO
23. Do you have problems associated with your menstrual period?.........................YES or NO
24. Are you nursing?..YES or NO
25. Are you taking birth control pills?..YES or NO

Acknowledgement & Agreement:

❑ I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Name of Patient ___________________________________Date____________________

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Signature of Patient or Parent

WESTCHESTER ORAL & MAXILLOFACIAL ASSOCIATES, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Westchester Oral & Maxillofacial Associates

I (Print Name) ________________________________ have received notice of this office's Notice of Privacy Practices.

____ Date___________________
Signature of Patient or Parent

FOR OFFICE USE ONLY

❑ Individual refused to sign
❑ Communications barriers prohibited obtaining acknowledgement
❑ An emergency situation prevented us from obtaining acknowledgement
❑ Other (please specify)

ADA American Dental Association®
America's leading advocate for oral health

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

AMERICAN DENTAL ASSOCIATION

Westchester Oral & Maxillofacial Assoc, PLLC
Patient Financial Policy

Thank you for choosing Westchester Oral & Maxillofacial Associates as you dental provider. Please be assured that your care is of the utmost importance to us.

Thank you for the time to review our policies. Your clear understanding of our financial policy is important to our professional relationship with you. Please feel free to ask any questions you may have.

Co-Payments

We are required to collect your co-payment at the time of visit. There will be a $15 surcharge applied to your balance if you co-pay is not paid at time of visit. WOMA accepts cash, check and credit cards.

Insurance

We will require a copy for your dental and medical insurance card for our files. Please inform us of any change in your Insurance coverage. Please remember, Insurance is never a guarantee of payment.

Participation plans-WOMA participates with most insurance plans. In order to properly bill your insurance company we require all necessary insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. You are responsible for any co-payments, deductibles, or non-covered services not paid by your insurance.

Non –Participating Plans-If we are out of network for your insurance, payment is due at time of service.

Self-Pay

Payment is expected at time of visit. We offer payment plans in the office if the visit exceeds $1,000.

Cancellation/No Show Policy

A $75 will be applied to your balance if you do not arrive for an appointment and do not cancel prior to the late cancel period.

PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full responsibility for services rendered by Westchester Oral & Maxillofacial Assoc, PLLC. I understand that I am responsible for the prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise a $15 surcharge will be added to my bill in addition to the applicable co-pay charge.

Name of Patient ________________________________Date__________________

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Signature of Patient or Parent