PATIENT INTRODUCTION

Referring Dentist _____ Family Doctor _____

_____ _____ _____ _____
Last Name First Name M.I. SSN

_____ _____ _____ (_____)_____ (_____)_____
D.O.B. (mm/dd/yy) Sex Marital Status Home Phone ☐ ✓ Preferred # Alternative/Cell Phone ☐ ✓ Preferred #

_____ _____ _____ _____ _____
Address Apt. City State Zip Code

_____ _____ (_____)_____
Employer / Employer Address Occupation Business Phone

_____ _____ _____ _____
Spouse's Name D.O.B SSN Employer

_____ _____ (_____)_____
EMG Contact / Nearest Friend or Relative Relationship to Patient Phone

INSURANCE

Dental Insurance	Policy Holder	Policy # / Group #
1 _____	_____	_____/_____
2 _____	_____	_____/_____
Medical Insurance	**Policy Holder**	**Policy # / Group #**
1 _____	_____	_____/_____
2 _____	_____	_____/_____

I have completed this form and fully and completely to the best of my knowledge. I understand that even though I have insurance, I am responsible for payment for what insurance does not cover.

_____ _____
Date **Signature** of Patient, Parent or Responsible Party

***** PLEASE COMPLETE THE SECTION BELOW IF SOMEONE **OTHER THAN THE PATIENT** IS RESPONSIBLE FOR THE **INSURANCE** POLICY

_____ _____ _____ _____
Last Name First Name M.I. SSN

_____ (_____)_____ _____
D.O.B, (mm/dd/yy) Phone Relationship To Patient

_____ _____ _____ _____ _____
Address Apt. City State Zip Code

_____ (_____)_____
Employer / Employer Address Business Phone

Southern NJ Oral Surgery PA

Name _____ DOB _____ Sex ____

Address _____ City/State/Zip _____

Preferred Phone # _____ Occupation _____

Drug Allergies _____

List any medications that you are taking _____

_____

DO YOU HAVE A HEALTH HISTORY OF : (please answer all)

Asthma: **No** / **Yes** - Describe last attack _____

Anemia: **No** / **Yes** - What type? _____

Bleeding Disorder: **No** / **Yes** - What type? _____

Heart Attack: **No** / **Yes** - When? _____, Heart Murmur: **No** / **Yes** , Chest Pain: **No** / **Yes** ,

Heart Disease: **No** / **Yes** , Other Heart Problems: **No** / **Yes** - Please describe: _____

Rheumatic Fever: **No** / **Yes** , Rheumatic Heart Disease: **No** / **Yes** _____

Diabetes: **No** / **Yes** - ☐ Type 1 ☐ Type 2 _____

Epilepsy: **No** / **Yes** , Convulsions: **No** / **Yes** , Seizures: **No** / **Yes** _____

Stomach or Intestinal Problems: **No** / **Yes** _____

Kidney Problems: **No** / **Yes** _____

Bladder Problems: **No** / **Yes** _____

Prostate Problems: **No** / **Yes** _____

Blood Pressure Problems: **No** / **Yes** _____

Pregnant: **No** / **Yes** - How far along? _____

Hepatitis: **No** / **Yes** , Jaundice: **No** / **Yes** , Liver Disease: **No** / **Yes** _____

Thyroid Problems: **No** / **Yes** _____

Artificial Joints: **No** / **Yes** _____

Tobacco Use: **No** / **Yes** - How much? _____

Alcohol Use: **No** / **Yes** - How much? _____

History of recreational drug use? **No** / **Yes** _____

List any operations that you have had: _____

Describe any medical problems not listed above: _____

_____

Signature Patient/Legal Guardian _____ Today's Date _____

PLEASE REVIEW THE FOLLOWING, FOR YOUR INFORMATION

You will be meeting with the doctor to discuss the possibility of some dental or oral surgery for an evaluation of a specific problem that you are having.

Please provide the doctor with a note or referral that your dentist or physician has given you.

The doctor will review your medical history with you in detail. Please be aware of ALL medications that you are currently taking and ALL medications that may have caused an allergic reaction or adverse reaction.

The doctor will then discuss the reason for today's visit and examine you. If a problem is related to the teeth, jaws or tissue attached to the jaws (gums, palate, etc.) a recent panoramic x-ray of appropriate quality is needed to further your treatment.

The doctor will evaluate the problem and recommend treatment if needed. The recommendation for treatment will emphasize safety and comfort for you. Very often relaxing medications are given (if you are a candidate for them) before treatment to make your experience comfortable and relaxing.

The doctor will discuss benefits and possible risks of your proposed procedure. If you will be having a tooth extracted there are four common areas that are discussed in all cases. Mostly these possibilities are rare but some people have increased risk of one or more of these issues. Your doctor will discuss them with you in detail.

For all tooth extractions, the following considerations can occur:

1) Adjacent teeth, if present, can react to an extraction with soreness or pain that usually resolves. RARELY an adjacent tooth with no fillings or cavities may require root canal treatment to calm it down. Adjacent teeth with large fillings, crowns or cavities may be more likely to need root canal treatment after an adjacent tooth is extracted. This is not very common if the adjacent tooth has had no symptoms, but it is possible.

2) Caps, crowns and fillings as well as normal tooth or root structure of an adjacent tooth can sometimes come off, loosen or be chipped or damaged due to the very close positioning of teeth in some situations. These may require repair by your dentist. This is also not common, but possible with any tooth extractions.

3) Upper back teeth often sit under the sinus of the upper jaw (a normal air space behind your cheek). Sometimes an opening will occur in the sinus when an upper back tooth is removed that normally heals on its own in about eight weeks with proper home care. If this is a possibility with your treatment, the doctor will inform you. Usually patients that have this are asked not to blow their nose or smoke for six to eight weeks to allow natural healing. Rarely, an opening in the sinus may not close and you may need a procedure to close it weeks or months later. This additional procedure is not common but possible with any upper back tooth removal.

4) Lower back teeth sit over the sensory (feeling) nerve of the lower jaw. In some cases, a tooth root is close or in contact with that nerve and may bump or bruise it when it is removed. This can in some cases produce a tingling or numbness to the lip, chin or tongue. If this occurs, the healing process is usually slow and can take up to 12 to 18 months to improve. Some improvement can be partial, or rarely, not at all, and a partial or complete permanent numbness can occur in rare cases. The dental injection used for lower fillings, root canals or extractions has even been known to cause permanent numbness in about 1 in 100,000 dental injections. This is of course very rare and can occur with any dental work.

5) Lower back tooth extractions can very rarely result in a fracture or break of the jaw. This is very rare but some thinner people with thin jaws may be at an increased risk of this occurring. Also, teeth that are very low in placement in the bottom jaw may carry an increased possibility of this. Your doctor will usually recommend avoiding very hard foods for months after tooth removal in cases like this to avoid any injury to the jaw and allow it to become very strong or stronger once again.

The doctor will discuss your treatment and your medical condition. If you are taking any blood thinners like aspirin, Coumadin, warfarin, Plavix, pletal, or others, you must inform your doctor so that your treatment can proceed properly and safely. The doctor must be told all medications that you are currently taking.

If you have taken Fosamax, Boniva, Actonel, Aredia or Zometa in the past or present you must inform the doctor as the drug manufacturers of the above medications have major warnings that must be discussed with the doctor. (These medicines are used for osteoporosis, osteopenia and certain types of cancer including breast cancer and multiple myeloma.)

If you are or may be pregnant, you must inform the doctor. Your doctor may wish to consult with your physician on certain medical issues that could influence your treatment.

The doctor will answer all of your questions and plans to maximize your comfort and safety in the treatment process.

Please acknowledge that you have read and understand the preceding information by signing below:

Signature Patient/Legal Guardian _____

Print Name _____ Today's Date _____

The **HIPAA Notice of Privacy Practices** describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

This notice was published and becomes effective on/or before April 14, 2003.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

Signature Patient/Legal Guardian _____

Print Name _____ Today's Date _____