RIDGEFIELD
Oral and Maxillofacial Surgery, LLC
Steven Smullin, D.M.D., M.D.

General Patient Information

Welcome to Ridgefield Oral Surgery. So that we may file your dental insurance claims, please provide us the following information. All information is kept strictly confidential.

Patient's Full Name: _____ Date Of Birth: _____ Age:_____ Sex: _____

Soc. Sec. #:_____ Phone #:_____ Secondary Phone #:_____

Address:_____ Apt#:_____ City:_____ State:_____ Zip: _____

Email: _____ Employer: _____ Employer Ph #: _____

Emergency Contact Name: _____ Emergency Contact Ph#_____ Relationship: _____

Dentist: _____ ***Primary Care Physician***: _____

Chief Dental/ Facial Compliant (please share with us why you are here today): _____

_____

Responsible Party (Financial)

If the patient is under age 18, we will need the information of the individual who is responsible for the account.

Name: _____ Date Of Birth: _____ Age: _____ Sex: _____

Soc. Sec. #:_____ Phone #:_____ Secondary Phone #:_____

Address: _____ Apt#:_____ City: _____ State:_____ Zip: _____

Relationship: _____ Email: _____ Employer: _____

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

Employer Ph #: _____ Occupation: _____

Insurance Information

Primary Dental Insurance Carrier: _____ Insured Name: _____

Insured D.O.B: _____ ID #:_____ Group#:_____

Insured Ph. #:_____ Insured Employer: _____

Secondary Dental Insurance Carrier: _____ Insured Name: _____

Insured D.O.B: _____ ID #:_____ Group#:_____

Insured Ph. #:_____ Insured Employer: _____

Method of Payment (Please circle one): **Credit Card** **Check** **Cash**

Pharmacy: _____ **Pharmacy Ph. #**_____

Signature_____ **Date:** _____

(Parent or Legal Guardian If Minor)

Ridgefield Oral and Maxillofacial Surgery Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

Gender: _____ Age: _____ Height: _____ Weight: _____

Your medical history is important to the care you will receive, so please be complete and honest. Please circle your responses.

Please describe any symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a doctor's care for a particular problem at this time? Yes No

If yes, why? _____ Date of last physical exam _____/_____/_____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?_____

Have you ever had surgery? Yes No

If yes, when and what for? Date of surgery:_____ Reason for surgery:_____

Date of surgery:_____ Reason for surgery:_____

PAST MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Arthritis?	Yes	No
Stomach ulcers or colitis?	Yes	No	Significant weight loss or gain?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Glaucoma?	Yes	No	Sleep apnea?	Yes	No
Diabetes?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Any cancer, radiation, or chemotherapy?	Yes	No			

Describe: _____Date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? Please circle your responses. If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer/tumors?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Sleep apnea?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you may be pregnant? Yes No

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Ridgefield Oral and Maxillofacial Surgery Health History Form

Patient's Name _____ Date of Birth _____/_____/_____

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Prescription pain medication?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Heart medications?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Steroids (cortisone, prednisone, etc.)?	Yes	No	Blood pressure medications?	Yes	No
Antianxiety agents, antidepressants or other psychiatric medications?	Yes	No	Bisphosphonates, medications to strengthen your bones (ex. Prolia, Fosamax, Boniva, Reclast, Actonel, Aredia, Zometa), IV medications, or any other cancer drugs? If yes, list drugs used and time of use below.	Yes	No

Please list any specific medications indicated above and/or any other medications not listed above that you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

Medication	Dosage	Medication	Dosage

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Other drug or food allergies not listed above: _____

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Substance abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and accurate.

_____ _____
Signature of patient, parent or guardian Date

_____ _____
Printed name of patient, parent or guardian/Relationship Doctor's Signature

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At Ridgefield Oral Surgery, we are HIPAA (Health Insurance Portability and Accountability Act) compliant. HIPAA is a US law designed to provide privacy standards to protect patients' medical records and health information. In order to provide your care, we require you to release any medical and dental records that pertain to your care, including but not limited to the diagnosis, radiographs, and records of treatment or examination. **You agree that this information can only be discussed with yourself or a parent if you are a minor, your referring dentist/physicians and your insurance carrier. Should you wish this information be discussed with anyone else, such as another family member, a conservator, power of attorney, legal guardian, or a medical proxy, please list their name and relationship below:**

□-Spouse □-Mother □-Father □-Children □-Other _____

We assume that we may contact you with messages containing detailed medical information as follows:

- By telephone at any number you have provided to us, or
- In writing at any address provided, or
- By email through any email address you have provided

(Please note that appointment reminders may be sent by mail, voicemail, email, or any combination of the above.)

Under HIPAA, you have the right to restrict our communications with you. If you wish to restrict our communication with you, please indicate this below. We will honor your request unless an emergency exists.

Check the box for communication restrictions

At my home telephone ( ) _____-_____

□ Please leave a message with call-back information only

□ Please do not leave messages at home

At my cell telephone ( ) _____-_____

□ Please leave a message with call-back information only

□ Please do not leave messages on my cell

At my email address _____

□ Please leave a message with call-back information only

□ Please do not leave messages on my email

At my work telephone ( ) _____-_____

□ Please leave a message with call-back information only

□ Please do not leave messages at work

Patient Name: _____ **Date:** _____

Signature: (Parent or Legal Guardian if Minor) _____

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FINANCIAL POLICY

We strive to deliver the finest care at the most reasonable cost to our patients; therefore, payment is due at the time service is rendered unless other arrangements have been made in advance. For your convenience, we accept Visa, MasterCard, Discover, American Express, cash and check. All checks need to clear prior to treatment being rendered. We do not accept checks the day of treatment. As part of your payment, we do accept many dental insurance plans, and our financial coordinators are happy to assist you in understanding your plans benefits. If you do not have insurance, then the entire fee is due at the time of your visit unless prior arrangements have been made.

Please remember you are responsible for all fees charged by this office regardless of your insurance coverage. Medical and dental insurance is a contract between the patient and the insurance company, and therefore the patient (or guarantor) is ultimately responsible if the insurance company does not cover the associated treatment costs.

If applicable, we will send you a monthly statement. Most insurance companies will issue payments within four to six weeks. Please call our office if your statement does not reflect your insurance payment within that period. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated.

If you have insurance, we would be happy to help you file your claims. We require that you bring along your insurance information at the initial visit. Some insurances require pre-authorization prior to treatment. At the consultation appointment, an estimate out of pocket fee will be determined by our financial coordinators. If we have not received pre-authorization or you do not have insurance, then the estimated fee is due at the time of treatment and any remaining balances may be due at a later date. Please remember that all fees and amounts due are estimates and can change.

Every attempt will be made to maximize your insurance benefit and reimbursement. Often this can be a time-consuming process, so please be patient and understand that we are making every effort possible to help you.

If you need assistance or have questions regarding your account, please contact us at (203) 403-3686.

Signature of patient or legal guardian: _____ Date: _____