PATIENT HEALTH HISTORY

NAME_____ AGE _____ SEX _____ REFERRING DOCTOR_____

CHIEF COMPLAINT_____ ALLERGIES _____

MEDICATIONS _____

ALL NON PERSCRIPTION MEDICATION_____

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____ PULSE _____ DATE OF BIRTH_____

PREFERRED PHARMACY_____

If no changes: Initials _____Date_____ **CONFIDENTIAL OFFICE INFORMATION**

GENERAL HEALTH – Good ( ) Fair ( )Poor ( )

Please CHECK or put an X by yes or no before any condition which applies now or has applied in the past

YES NO		YES NO		YES NO		YES NO	
( ) ( )	HEART CONDITION	( ) ( )	CHEST PAIN	( ) ( )	HIGH BLOOD PRESSURE	( ) ( )	ANEMIA
( ) ( )	LOW BLOOD PRESSURE	( ) ( )	HEART MURMUR	( ) ( )	HEART ATTACK	( ) ( )	HIV/AIDS/ARC
( ) ( )	RHEUMATIC FEVER	( ) ( )	ARTIFICIAL HEART VALVE	( ) ( )	SHORTNESS OF BREATH	( ) ( )	GLAUCOMA
( ) ( )	JOINT REPLACEMENT	( ) ( )	SWOLLEN ANKLES	( ) ( )	FAINTING SPELLS	( ) ( )	DIABETES
( ) ( )	CONVULSIONS	( ) ( )	NERVOUS DISORDERS	( ) ( )	DIZZINESS	( ) ( )	STROKE
( ) ( )	PERSISTENT COUGH	( ) ( )	EMPHYSEMA	( ) ( )	HAYFEVER	( ) ( )	ASTHMA
( ) ( )	RECENT COUGH	( ) ( )	KIDNEY DISEASE	( ) ( )	BLADDER INFECTION	( ) ( )	BRONCHITIS
( ) ( )	SPLENECTOMY	( ) ( )	TRANSFUSION	( ) ( )	BLEEDING DISORDER	( ) ( )	DRINK ALCOHOL
( ) ( )	PREGNANT (presently)	( ) ( )	CANCER/CHEMOTHERAPY	( ) ( )	BISPHOSPHONATES	( ) ( )	ILLEGAL DRUG USE
( ) ( )	BREASTFEEDING (presently)			( ) ( )	Do you chew smokeless tobacco?	( ) ( )	REC. DRUG USE

( ) ( ) TB (including having lived with someone with TB)
( ) ( ) Do you smoke cigarettes or use a Vape Pen? Packs a day _____ #Yrs___
( ) ( ) Have you ever taken Cortisone, Prednisone or a steroid (pills or injections)?
( ) ( ) Have you ever had prolonged bleeding following any surgery?
( ) ( ) Have you ever taken Anticoagulants (Blood Thinners)?
( ) ( ) Have you seen a physician during the last year?
( ) ( ) Have you ever taken medicines for high blood pressure or heart disease?
( ) ( ) Have you ever had hepatitis or liver trouble?
( ) ( ) Do you have difficulty breathing through your nose?
( ) ( ) Do you wear contact lenses?
( ) ( ) Have you ever had hives, wheezing, or difficulty breathing following any medication?
( ) ( ) Have you ever been put to sleep? Problems or complications? _____
( ) ( ) Is there any condition concerning your health the doctor should know? _____
( ) ( ) List any previous surgeries or hospitalizations: _____
_____

I certify that the above medical history is complete and correctly recorded to the best of my knowledge.

PATIENT SIGNATURE(parent if minor) _____**Date**_____

FOR THE DOCTOR ONLY

ROS:( ) SOB ( ) CP ( ) HA ( ) MS ( ) N/V
( ) CVA ( ) DVT ( ) OSA ( ) GERD
( ) BLEED ( ) SZRS ( ) CONFUSION
( ) RECENT FEVER/CHILLS
( ) PREG ( ) ALL NEGATIVE

H/O Surgical Complications? Y N
H/O Anes. Complications? Y N
H/O Regular Exercise? Y N
Explain_____

ORAL EXAMINATION

TMJ ( ) Non Painful ( ) Painful 1/10_____ R L Click R L **SOFT TISSUE** ( ) FOM soft/non-tender ( ) Salivary flow adequate ( ) No lesions
MYOFACIAL ( ) Non Painful ( ) Painful 1/10_____ R L M T MIO_____ ( ) **Bruxism**
MALLEMPATI 1 2 3 4 **IIG** 1 2 3 4 5 **TONSIL** 0 1 2 3 4 4+ **SNORE** Y N **HYGIENE** ( ) Adequete ( ) Poor

DENTAL EXAMINATION

Painful _____
Caries/Fx _____
Operculum_____
Pericornitis_____
Other_____
_____

RADIOGRAPHIC EXAMINATION ( ) Pano ( ) Bitewing ( ) CBCT

Peri coronal RL_____
Peri apical RL _____
Caries _____
Malposed _____
Bone/Attchemnt loss_____
_____

IMPLANT EXAMINATION

KT Voume A I _____
Bone Volume A I _____
_____
_____
_____

CV:_____ LUNGS:_____

A B C D E F G H I J
T S R Q P O N M L K

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

DIAGNOSIS

ASA 1 2 3 4 5 MET 1 2 3 4 4+

TE_____
TI_____
PB_____
CB_____
Difficult CB_____
Primary_____
Non-Restorable_____
_____

RECOMENDATIONS

_____
_____
_____
_____
_____

LA LA/N2O IVA GEN/HOSP MAC Degree 1 2 3 4 5 6 7 8 9 10 11 12

PATIENT REFUSAL ( ) CBCT ( ) Coro ( )_____ ( ) Pt discussed/chose to remove ASYMPTOMATIC teeth also

PRE OPERATIVE NEEDS ( ) CBCT ( ) H/P per PCP ( ) INR ( ) Blood Glucose ( ) Inhaler

Discussed/All Questions Answered Regarding:

( )OAF,Anes, Nerve/Lip/Tongue Numb,Infec, Lip Burn, Implant Loss as Indicated
( ) Risks/ Benefits/ Alternatives/ Discussed Thoroughly, ALL QUESTIONS ANSWERED
( ) Consent Signed/ Discussed Observe vs. Perform Discussed Tmt.-*Pt.Chose to Proceed as Described Above*
( ) Pre-op Teaching/All Questions Answered
( ) Take regular medication in AM with sip of water
( ) NPO/Escort/Pre-op Teach Completed

Prescriptions:

( )Clindamycin 300 mg #20 QID X 5d
( ) Amoxicillin 500 mg #15 TID X 5d
( ) Chlorhexidine rinse – Dispense 1 bottle
( ) Amoxicillin 500 mg #4 1 hour prior

Assistant Signature_____**Date**_____ **Dr. Signature**_____

Stephen W. Holm, DMD / Sherdon W. Cordova, DDS

PATIENT REGISTRATION FORM

Patient Name: _____ SSN: _____-_____-_____

Legal Name (if Different) _____

Date of Birth: ____/____/____ Sex: ____ Marital Status: _____

Mailing Address:_____
(Street) (City) (State) (Zip)

Physical Address if different_____Email:_____

Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Preferred method of contact: (__)home (__)cell(__)work (__)email

Employer Name: _____ Employer Phone #: (____) _____

Employer Address: _____
(Street) (City, State, ZIP)

Primary Care Physician: _____
(Name) (Phone Number)

Referring Dentist: _____Current Orthodontist:_____

Responsible Party (complete if different from patient, IF PATIENT IS 18YRS. ACCOUNT WILL BE IN THEIR NAME)

Guarantor Name: _____DOB_____/____/_____ SSN: _____-_____-_____

Relationship to patient: _____ Address: _____

Phone Number: (____) _____ Employer Name: _____

Employer Address: _____ Employer Phone #: (____) _____
(Street) (City, State, ZIP)

Emergency Contact

Name: _____ Home #: (____)_____ Other #: (_____)_____Relationship_____

If you have State Insurance (IE, Molina, Apple Health, Medicaid) note that our Doctors are NOT CONTRACTED

INSURANCE INFORMATION

Primary Dental Insurance Company: _____ **ID Number**: _____

Address: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder SSN: ____-_____-_____

Policy Holder Date of Birth: _____/_____/_____ **Employer**: _____

Secondary Dental Insurance Company: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder SSN: ____-_____-_____

Policy Holder Date of Birth: _____/_____/_____ Employer: _____

Medical Insurance Company: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder Name: _____ Policy Holder SSN: ____-_____-_____

Policy Holder Date of Birth: _____/_____/_____

Is this visit due to a job related injury or automobile accident? Yes ( ) No ( ) *If yes, please notify the receptionist*

I authorize the release of any information necessary to process the claim to my insurance companyand request payment of benefits to Dr. Stephen W. Holm, DMD / Dr. Sherdon W. Cordova, DDS. I acknowledge that I am financially responsible for payment whether or not I am covered by insurance.

SIGNATURE: _____ DATE: _____

ORAL AND FACIAL SURGERY
Stephen W. Holm, DMD / Sherdon W. Cordova, DDS

RELEASE OF INFORMATION

Patient name: _____ Date of birth: _____/____/_____

A copy of the office HIPAA Privacy Policy is available at the front desk for your convenience. I authorize the release of any medical information necessary to process the claim to my insurance company or to any medical facility necessary to complete my treatment.

Please check one of the following:

( ) In addition, I authorize the release of information including the diagnosis, records, examination rendered to me and all billing and claims information to the following people:
(Please list by name)

( ) Spouse: _____

( ) Children: _____

( ) Parents: _____

( ) Other: _____

_____

( ) Information is not to be released to anyone other than my insurance company or a medical facility.

This Release of Information will remain in effect until terminated by me in writing.

Patient signature :(parent if minor) _____ Date: ___/__/___

Relationship to patient: _____

We are pleased to welcome you as a patient. Our primary mission is to deliver the best and most comprehensive oral and maxillofacial surgery care available. The purpose of this policy is to empower you by giving you a clear understanding of your financial responsibility with regard to any and all shared costs, co-pay amounts, deductibles, and any balance not paid by your insurance or employer plan. **Our consultation fee is $100.00 (this includes a panoramic x-ray). There may be additional cost, for any additional diagnostic imaging.**

As a *courtesy* to you, we will happily submit your insurance claim. It is your responsibility to know what your insurance benefits are. We do our best to estimate your insurance coverage but please remember that it is *just an estimate* and ultimately, you are responsible for any unpaid balances. Payment of your insurance co-payment is due and collected on the date of service.

We are happy to offer these choices so that you can select a payment option that best fits your needs.

Cash – includes money orders and personal check and is due at time of service.
******PLEASE NOTE THAT WE DO NOT CARRY CHANGE IN OUR OFFICE******

Insurance – We will bill your dental insurance as a courtesy to you but you are responsible for any insurance co-pay on day of service. **NOTE: Our Doctors are NOT CONTRACTED with, any Medical Insurance, Medicare, or Medicaid. We will not be able to bill Medicare or Medicaid and you will not be able to bill them yourself, as we are not contracted with them. We also do not work with Crime Victim Claims.**

We accept **Visa, Master Card** and **Discover**.

CareCredit® – **(must have approval prior to appointment**) patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits:*

- Flexible financing options
- No annual fees or prepayment penalties
- Quick and easy application
- Receive a credit decision almost immediately
- Start your recommended treatment immediately*

Again, we are pleased to welcome you as a member of our client family.

I have read, understand and agree to the financial policy for Dr. Stephen Holm, DMD / Dr. Sherdon Cordova, DDS.

Signature _____ Date _____

***Subject to credit approval**