PANHANDLE ORAL & MAXILLOFACIAL SURGERY

(Please complete in full – ink pen only)

PATIENT's Legal Name _____ Nickname _____
(first) (middle) (last)

Address _____
(no. & street) (city) (state) (zip)

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Birth date _____ Age _____ Sex _____ SSN _____

If Student: ☐ Full-time ☐ Part-time School _____

Employer _____ Occupation _____

Home # _____ Cell # _____ Work # _____ Email _____

PHYSICIANS (Full names please)

Referred by: _____ Phone # _____

General Dentist _____ Phone # _____

Orthodontist _____ Phone # _____

Family Physician _____ Phone # _____

☐ **SPOUSE** ☐ **PARENT** **or** ☐ **GUARDIAN** Name _____

Address (if different) _____
(no. & street) (city) (state) (zip)

Birth date _____ Marital Status _____ SSN _____

Employer _____ Occupation _____

Home # _____ Cell # _____ Work # _____ Email _____

PERSON RESPONSIBLE FOR ACCOUNT ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify) _____

Name (if not already given) _____ Birth date _____ SSN _____

Address (if different) _____
(no. & street) (city) (state) (zip)

Employer _____ Occupation _____

Home # _____ Cell # _____ Work # _____ Email _____

EMERGENCY CONTACT – Contact friend/relative **(NOT LIVING WITH YOU)**

Name _____ Relation to Patient _____

Home # _____ Cell # _____ Work # _____ Email _____

DENTAL INSURANCE **(IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)**

Insurance Co. _____ Phone # _____

Insurance Address _____

Insured's Name _____ Birth date _____ Relation to Patient _____

SSN _____ Policy/Certificate # _____

Employer's Group Name _____ Group # _____

Do you have secondary dental/medical? If so, please inform.

MEDICAL INSURANCE (IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. _____ Phone # _____

Insurance Address _____

Insured's Name _____ Birth date _____ Relation to Patient _____

SSN _____ Policy/Certificate # _____

Employer's Group Name _____ Group # _____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the physician or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper surgical care. I authorize the taking of photographs, radiographs and other diagnostic records before, during, and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **Bryan F. Bailey, DDS, PA** to release any information (via mail or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to **Bryan F. Bailey, DDS, PA** insurance benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

_____ _____ _____

Signature of Patient **Signature of Guardian (if minor)** **Date**

MEDICAL AND DENTAL HISTORY

Patient's Name _____ ☐ Male ☐ Female

Date of Birth _____ Age _____ Weight _____ Height _____

Patient's Current Dentist _____ Date of last appt: _____

Patient's Current Physician _____ Date of last appt: _____

Referred to our office by ☐ Self ☐ Friend ☐ Dentist ☐ Physician ☐ Yellow Pages

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. Additional space has been allowed on the bottom of this form for your use in fully explaining complex medical problems or concerns. Thank you!

Please list your reason(s) for this visit _____

Please list any medical problems you have _____

_____

PLEASE LIST CURRENT MEDICATIONS (including non-prescriptions/alternative/herbal) _____

_____

PLEASE LIST ALL DRUG ALLERGIES (including past and present) _____

_____

PLEASE LIST ALL PREVIOUS SURGERIES OR HOSPITALIZATIONS _____

_____

***Please check all conditions below that apply with a checkmark to indicate* YES**

MEDICAL

High Blood Pressure ☐
Chest pains or heart attack ☐
Stroke ☐
Rheumatic Fever ☐
Shortness of breath or swollen ankles ☐
Heart trouble, murmur, mitral valve prolapse ☐
Prosthetic devices (heart, valve, hip, etc) ☐
Lung diseases (TB, emphysema, etc) ☐
Asthma ☐
Allergies or hay fever ☐
Sinus problems ☐
Mouth breathing or excessive snoring ☐
Ulcers or stomach problems ☐
Diabetes ☐
Hepatitis or liver disease ☐
Kidney or bladder disease ☐
Thyroid problems ☐
Connective tissue disease ☐
Arthritis or rheumatism ☐

Cancer (type & year) ☐
Serious illness not listed (list below) ☐
Subject to prolonged bleeding or bruise easily ☐
Wear contact lenses ☐
Glaucoma ☐
Epilepsy, convulsions, or seizure history ☐
Psychiatric therapy or emotional problems ☐
Sexually transmitted disease ☐
Pregnant or possibly pregnant? ☐
Taking birth control pills ☐
Drink coffee (_____ cups per day) ☐
Use of tobacco (types & how much?) ☐
Consume alcoholic beverages? ☐
Pain, popping, catching, locking in jaw joints ☐
Clench or grind your teeth? ☐
Wake up with sore jaws? ☐
Frequent headaches (How many per week? _____) ☐
Dizziness, ringing, pain in ears? ☐
Tenderness or stiffness in the jaw, neck, or back? ☐
History of TMJ (jaw joint) problems ☐

Taking diet pills (prescription or non-prescription..... ☐

DENTAL

Treated for or diagnosed with gum disease..... ☐
Treated for or consulted for orthodontic therapy..... ☐
Previous oral surgery..... ☐
Dental x-rays in the last year? ..... ☐
Excessive fear of dental treatment..... ☐
Brush your teeth (how often?) _____..... ☐

Floss your teeth (how often?) _____..... ☐
Bad breath or unpleasant taste in mouth..... ☐
Bleeding gums/Sore teeth..... ☐
Gags easily..... ☐
Tooth sensitivity..... ☐
Fever blisters or mouth ulcers..... ☐
Suck your thumb, finger, lip (now or in the past?) ..... ☐
Tongue thrusting habit..... ☐
Place a high priority on keeping natural teeth..... ☐

Please use this space to expand on the previous information or add anything else you feel is important:

The above information is accurate and complete to the best of my knowledge. I understand that the staff at Dr. Bryan Bailey's will make every effort with my insurance company for reimbursement; however, I do understand that any remaining balance after insurance is still my responsibility.

The staff here at Dr. Bryan Bailey's office will keep your files a minimum of five years.

Patient Signature_____ Date_____

IF MINOR – Parent or Guardian Signature_____ Date_____

PLEASE SIGN ABOVE