Jordan Oral and Maxillofacial Surgery
Robert D. Jordan, DDS

General Patient Information

I was referred by Dr. _____

Patient Information

Patient's last name _____ First _____ Middle Initial _____

Address (number, street or apt#)_____

City _____ State _____ Zip _____

Phone # (best number to reach you) _____

Mailing address if different from above _____

City _____ State _____ Zip _____

Social security # _____-_____-_____ Birth date _____

Employer _____ Occupation_____

Age _____ Sex: ■ Male ■ Female Marital status: ■ Single ■ Married ■ Divorced

Maiden name _____ Spouse's name_____

Spouse's social security # _____-_____-_____ Spouse' birth date _____

Spouse's employer _____ Spouse's occupation _____

Complete Only If You Are A Minor

Father's name _____

Social security # _____-_____-_____ Birth date _____

Employer _____ Occupation_____

Years with employer _____ Work phone #_____

Mother's name _____

Social security # _____-_____-_____ Birth date _____

Employer _____ Occupation_____

Years with employer _____ Work phone #_____

Emergency Contact

Emergency contact not living at the same address _____

Best phone # to contact _____ Relationship_____

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Patient Health History

Patient name _____ Date of birth_____ Today's date_____

ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of your last physical exam _____
4. Height _____ Weight _____
5. Are you now under a physician's care for a particular problem? ..... Y N
6. Have you ever had any serious illnesses, operations, or hospitalizations? ..... Y N
   If so, describe: _____
   _____

7. Do you have or have you ever had the following?

- A. Rheumatic fever or Rheumatic heart disease ..... Y N
- B. Congenital heart disease ..... Y N
- C. Cardiovascular disease (heart attack, heart trouble, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker) ..... Y N
- D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) ..... Y N
- E. Seizures, convulsions, epilepsy, fainting, dizziness ..... Y N
- F. Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily? ..... Y N
- G. Liver disease (jaundice, hepatitis) ..... Y N
- H. Kidney disease ..... Y N
- I. Diabetes ..... Y N
- J. Thyroid disease (goiter) ..... Y N
- K. Arthritis ..... Y N
- L. Stomach ulcers or colitis ..... Y N
- M. Glaucoma ..... Y N
- N. Osteoporosis ..... Y N
- O. Implants placed anywhere in your body (heart valve, pacemaker, hip, knee, etc.) ..... Y N
- P. Radiation (x-ray) treatment for cancer ..... Y N
- Q. Sinus or nasal problems ..... Y N
- R. Any disease, drug or transplant operation that has depressed your immune system ..... Y N

8. Are you using any of the following?

- A. Antibiotics ..... Y N
- B. Anticoagulants (blood thinners) ..... Y N
- C. Aspirin, Motrin, Aleve, Ibuprofen ..... Y N
- D. High blood pressure medications ..... Y N
- E. Steroids ..... Y N
- F. Tranquilizers ..... Y N
- G. Insulin or oral anti-diabetic drugs ..... Y N
- H. Digitalis, Inderal, Nitroglycerin, other heart drugs ..... Y N
- I. Are you taking, or have you ever taken bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ..... Y N
- J. Please list any and all medications taken, including prescription medications, herbal or holistic remedies, vitamins, or minerals: _____
  _____

9. Are you allergic to, or have you had an adverse reaction to the following?

- A. Local anesthesia (Novocaine, etc.) ..... Y N
- B. Penicillin or other antibiotics ..... Y N
- C. Sedatives or barbituates ..... Y N
- D. Aspirin or Ibuprofen ..... Y N
- E. Codeine or other pain killers ..... Y N
- F. Latex or rubber products ..... Y N
- G. Other allergies or reactions ..... Y N

If so, please list: _____
_____

10. Do you smoke or chew tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ..... Y N
12. Have you ever had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N

16. For Women Only

- A. Are you pregnant, or is there any chance you might be pregnant? ..... Y N
- B. Are you nursing? ..... Y N
- C. Are you using oral contraceptives? ..... Y N

It is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. P lease consult with you physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature _____ Date _____ Doctor's initials _____

MEDICAL UPDATE: I have read my health history dated _____ and confirm that it adequately states past and present conditions.

Date _____ Changes _____ Patient's signature _____ Doctor's initials _____

Date _____ Changes _____ Patient's signature _____ Doctor's initials _____

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Financial and Insurance Policy

PLEASE READ CAREFULLY AND SIGN

Basic financial policy: Payment in full for services rendered, We accept check, cash, debit cards, MasterCard, Visa, Discover, American Express, and Care Unit

Patients with insurance: As a courtesy to our patients we do accept assignment of benefits and will bill your insurance carrier provided proper paperwork is provided. Patients without proper insurance identification will be considered private pay and will be responsible for their balance on the day of service. It is the patient's responsibility to provide us with correct billing information. Incorrect information may cause delays in payment of your account. We will expect you to begin making "good faith" payments in the event your insurance processing goes over 90 days due to incorrect billing information given on the day of service. It is our policy to collect a 20% co-pay on the day of service in addition to any deductible that has not been met. We do our best to determine what your insurance will pay, but this is not always possible. You may owe an additional balance or we may owe you a refund.

Some benefit plans require pre-authorization and a specialist referral form from the primary care physician. It is your responsibility to know your insurance requirements. It will be helpful for you to call your insurance company prior to you appointment day to determine if you need any prior authorization.

It is your responsibility to know if your dental plan has a maximum payout per year and to know how much of this you have used for the year. (Some plans have a $1000.00 maximum, and some may have $1500-$2000 maximum per year).

Primary Insurance Company _____ ■ Medical ■ Dental

Name of Subscriber _____

Group # _____ ID # _____ Date of Birth _____

Primary Insurance Company _____ ■ Medical ■ Dental

Name of Subscriber _____

Group # _____ ID # _____ Date of Birth _____

Workman's compensation: We require the necessary insurance billing and employer authorization.

Personal injury cases: This office does not accept liens or bill auto accident, liability, or lawsuit-related case. The patient is responsible for payment at the time services are provided.

Divorced parents: We will be glad to bill the parent responsible for your child's account. However, both parents are responsible for a minor child's bill and both parents will be held accountable. We are not a party to your divorce decree. It will be up to the parents to determine "who owes what."

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF JORDAN ORAL AND MAXILLOFACIAL SURGERY

I will be paying today by: ■ Cash ■ Check ■ Credit Card ■ Care Credit

Signature of Responsible Party / Insured _____ Date _____

Signature of Human Resource Director _____ Date _____