NEW PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____ Sex _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone Numbers: Home: _____ Business: _____ Extension _____
Employer _____ Employer Address _____
Social Security # _____ Driver's License # & State _____
E-Mail Address _____ Cell Phone # _____

Account Responsible Party, if not patient:

Guardian _____ Date of Birth _____ Relationship _____
Address _____ Apt # _____ City _____ State _____ Zip _____
Phone Numbers: Home: _____ Business: _____ Extension _____
Employer _____ Employer Address _____
Social Security # _____ Driver's License # & State _____
E-Mail Address _____ Cell Phone # _____

Emergency Contact

Name/Relationship _____/_____ Daytime Phone: _____
Address _____ City _____ State _____ Zip _____

Insurance Information

MEDICAL

Insurance Co. _____
Address _____
_____
Phone Number: _____
Insured Party Name _____
ID # _____ DOB _____
Group # _____ Employer _____

DENTAL

Insurance Co. _____
Address _____
_____
Phone Number: _____
Insured Party Name _____
ID # _____ DOB _____
Group # _____ Employer _____

Fees & Payments

Payment is expected at the time services are rendered. A pre-determination of your insurance benefits and coverage will be obtained by this office prior to any treatment; however, this is based upon information received from your insurance company and is not a guarantee of payment. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by, or denied by, your insurance company.**

I hereby authorize the release of information necessary to process the claim(s). I authorize the use of this signature on all of my insurance claims, manual or electronic. I further authorize payment to the Pinnacle Oral Surgery, the benefits otherwise payable to me. I understand that I am responsible for the payment of services rendered in full, regardless of payments expected by an insurance company.

Signature _____ Date _____

CONSENT AND DIAGNOSTIC AIDS

I hereby give my consent to Pinnacle Oral Surgery, for any diagnostic aids necessary to evaluate, document and/or diagnose my condition. These shall include, but are not limited to, radiographs, models, and photographs. I further give Pinnacle Oral Surgery, any medical or dental information necessary to evaluate and/or treat my condition.

Signature _____ Date _____

PINNACLE
ORAL SURGERY SPECIALIST
WISDOM TEETH – DENTAL IMPLANTS

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Dentist: _____ Email Address: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK THOSE THAT APPLY

____High Blood Pressure	____Sinus Trouble	____Blood Disorder
____Heart Murmur	____Fainting Spells	____Epilepsy or Seizures
____Heart Disease	____Ulcer/Colitis	____Stroke/TIA
____Heart Attack	____Hepatitis A/B/C	____Thyroid Problems
____Rheumatic Fever	____Liver Disease	____Back/Neck Injury
____Ankle Swelling	____Diabetes Type I or II	____Arthritis
____Shortness of Breath	____Kidney Problems	____Tumor/Cancer (anywhere)
____Pneumonia	____Anemia	____Radiation/Chemotherapy
____Tuberculosis	____Hemophilia	____Aids or HIV+
____Asthma	____Emphysema	____Blood Transfusion

WOMEN:
Are you pregnant? _____ Are you nursing? _____ Taking birth control pills? _____
(Note – Antibiotics may neutralize the effects of birth control pills, theoretically allowing for conception and pregnancy)

OTHER MEDICAL PROBLEMS: _____

LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES: _____

_____

PROBLEMS WITH PREVIOUS GENERAL ANESTHESIA/IV SEDATION: _____

CURRENT MEDICATIONS: _____

_____

HAVE YOU TAKEN ANY DRUG(S) FOR OSTEOPOROSIS? _____
HAVE YOU **EVER** TAKEN ANY OF THE FOLLOWING MEDICATIONS? _____

_____ Aredia	_____ Fosamax	_____ Actonel	_____ Boniva
_____ Zometa	_____ Ostac	_____ Skelid	_____ Didronel

ALLERGIES TO MEDICATION: _____

ALLERGIC TO LATEX: _____ ALLERGIC TO SOY OR EGG: _____

DO YOU SMOKE/CHEW? _____ If yes, packs per day: _____ How many years: _____

ARE THERE ANY OTHER CONDITIONS CONCERNING YOUR HEALTH THAT YOUR DOCTOR SHOULD BE AWARE OF? _____

I have read and fully understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully. I will not hold Pinnacle Oral Surgery, or any member of the staff, responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE: _____ DATE: _____ Rev. 6/19

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Pinnacle Oral Surgery Specialist. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Pinnacle Oral Surgery Specialist reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	