PASQUAL
ORAL & MAXILLOFACIAL
SURGERY

WELCOME TO OUR PRACTICE

Patient Name____ Date of Birth___________________

Address____ SSN __________________________

City, State, Zip____ Home #_____________________________

If Child, Parent's Name_________________________________ Cell #_______________________________

E-mail____

Referring Dentist___________________________ Reason for visit___________________________________

Pharmacy_______________________ Location/#____

DENTAL INSURANCE

Dental Ins. Name_______________________________ Policy Holder____________________________

Member ID #_________________________________ Date of Birth_______________________________

MEDICAL INSURANCE

Medical Ins. Name_______________________________ Policy Holder___________________________

Member ID #_________________________________ Date of Birth_______________________________

AUTHORIZATION

The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize my surgeon and his designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment. I understand that I am financially responsible to John R. Pasqual, D.M.D., P.A. for any charges incurred by the above named patient, and promise to pay promptly, the amount of such charges which are not paid by any insurance carrier for any reason. Failure to pay in a timely manner may result in application of service charges to my account, or make me financially responsible for any charges incurred to collect my account, including court cost, attorney fees and up to 15% of my balance for collection agency fees.

I authorize release of any information relating to this claim to 3rd party payors. I hereby authorize direct payment to John R. Pasqual, D.M.D., P.A. of the insurance benefits otherwise payable to me.

X ____ **X** _____________________________

Signature of patient (Parent or Guardian if minor) **Date**

MEDICAL HISTORY

Name:____ **Sex:**___________ **Height:**____________ **Weight:**_____________

Current medications:____

____

Please indicate if you have a history of taking any of the below for osteoporosis/cancer.

	Yes	No	Duration		Yes	No	Duration
Aredia	☐	☐	____________________	Avastin	☐	☐	____________________
Reclast (Zometa)	☐	☐	____________________	Fosamax	☐	☐	____________________
Proilia	☐	☐	____________________	Actonel	☐	☐	____________________
Boniva	☐	☐	____________________	XGEVA	☐	☐	____________________

Allergies: ☐ Penicillin ☐ Codeine ☐ Latex ☐ Other ____

Primary Care Physician:

Name:____ **Phone:**____

Major illnesses, hospitalizations or surgeries:____

____

Substance history:	**Yes**	**No**
Tobacco Use	☐	☐
Narcotic/Substance/Chemical Dependency	☐	☐
Alcohol Dependency	☐	☐

Please indicate if you have a history of any of the following:

	Yes	**No**		Yes	No
Heart Disease	☐	☐	Anemia	☐	☐
Mitral Valve Prolapse or Valve Disease	☐	☐	Bleeding Tendencies	☐	☐
Palpitations / Irregular Heart Beats	☐	☐	Blood Transfusions	☐	☐
Pacemaker or Stents	☐	☐	Cancer or Metastasis	☐	☐
Rheumatic Fever / Endocarditis	☐	☐	Chemotherapy or Radiation Therapy	☐	☐
High / Low Blood Pressure	☐	☐	Alzheimer's / Dementia	☐	☐
Heart Murmur	☐	☐	Convulsions / Seizures	☐	☐
Chest Pain, Heart Attacks	☐	☐	Diabetes	☐	☐
Stroke, TIA	☐	☐	Sinus Disease or Allergies	☐	☐
Bronchitis	☐	☐	Glaucoma	☐	☐
Asthma	☐	☐	Hepatitis A, B, C	☐	☐
Ulcers / Acid Reflux	☐	☐	STD / Herpes / HPV	☐	☐
Emphysema / Lung Disease	☐	☐	HIV / AIDS	☐	☐
Pneumonia	☐	☐	Prosthetic Joint (hip, knee etc…)	☐	☐
Shortness of Breath	☐	☐	Psychiatric treatment	☐	☐
Liver Disease	☐	☐	Emotional Disorder	☐	☐
Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Steroid use or Immunosuppressant	☐	☐	Tuberculosis	☐	☐
TMJ problems	☐	☐	Is there a chance you are pregnant?	☐	☐
Jaw clicking / Popping	☐	☐	Breast Feeding / Nursing	☐	☐
Osteopenia / Osteoporosis	☐	☐	Sleep Apnea / Snoring	☐	☐

Note: Antibiotics may interfere with the effectiveness of oral contraceptives. You will need to use mechanical forms for one complete cycle. If you are pregnant, any treatment especially sedation we render might place your baby at risk.

Note: Taking multiple prescribed sedatives or narcotics may result in overdose and respiratory depression.

X ____ **X**____

Signature of patient (Parent or Guardian if minor) **Date**

Office use only: ____

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HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

(164.520 a)

I,_________________________________ understand that as a part of my healthcare, this facility originates and maintains
(Please Print Name)
health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of these uses and disclosures of my health information. I understand that:
*I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

*This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Please list any individuals (family, friends, etc.) that you authorize us to speak to regarding your appointment, treatment, and billing.

Name / Relationship	**Phone number**
____	_______________________________________
____	_______________________________________
____	_______________________________________
____	_______________________________________

Signature ____ **Date**______________________

Guardian's Signature (If a Minor) _______________________________ **Date**______________________

Print Guardian's name if applicable______________________________ **Date**______________________

I am giving John R. Pasqual, D.M.D., P.A. the authority to access my medical and dental records if necessary.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and other Healthcare Communications

I consent to receiving, by telephone call, text message, or voicemail transmission, instructions and other healthcare communications by or on behalf of the practice at the email/telephone number or text address I have provided in my patient record. The instructions may include, but are not limited to: pre-procedure instructions, educational information and prescription information. Other communications may include, but are not limited to, healthcare communications to family or designated representatives regarding treatment or condition, reminder messages regarding appointments, insurance or billing or requests for feedback about my visit and/or public-facing reviews. I authorize and acknowledge that these instructions and other communications may be transmitted using an automated system. If you do not wish to be contacted via text message, please inform the office.

FOR OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but it could not be obtained because:

___Individual refused to sign
___Communication barrier prohibited obtaining the acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (please specify)_____________________