Patient Information & Health History – Page 1 Date: ____________

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name_______________ M.I. __ Last____________________

Sex: ☐Male ☐Female Birth Date:___________ Age____ Soc. Sec. #___________________

Address________________________ City________________ State_____ Zip______________

Home Phone (____)_________ Cell Phone (____)_________ Email________________________

Driver's Lic. #_____________ Emergency Contact Name_______________ #(____)________

Student: ☐Full Time ☐Part Time ☐Not Student

School Name_______________________ School Address_______________________________

Marital Status: ☐Married ☐Divorced ☐Legally Separated ☐Widow ☐Single

Employed: ☐Full Time ☐Part Time ☐Retired ☐Not Employed

Do you belong to a PPO or HMO? ☐Yes ☐No

Employer____ Business Phone (____)___________

Personal Payment Type: ☐Cash ☐Check ☐Credit Card

Referral Information

Have you ever been a patient of our practice? ☐Yes ☐No

Has a family member ever been a patient of our practice? ☐Yes ☐No

Referred By_________________________ Dentist__________________________________

Medical Doctor______________________ Orthodontist_____________________________

Who will be responsible for your account?

☐Self (*if self, skip to next section*) ☐Spouse ☐Father ☐Mother ☐Other_______________

First Name_____________ Last Name_______________ Phone (____)____________________

Birth Date:___________ Soc. Sec. #__________________

Address________________________ City________________ State_____ Zip______________

Employer____ Business Phone (____)___________

Spouse or other guarantor information (*if different from above*)

Relation: ☐Spouse ☐Father ☐Mother ☐Other_______________

First Name_____________ Last Name_______________ Phone (____)_____________

Birth Date:___________ Soc. Sec. #__________________

Address________________________ City________________ State_____ Zip______________

Employer____ Business Phone (____)___________

Patient Information & Health History – Page 2 Date: ____________

Primary Dental Insurance

Insured Member: First Name_____________________ Last Name_________________________

Sex: ☐Male ☐Female Birth Date:____________ Soc. Sec. #__________________________

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other________________

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #__________________________ Group #___________________________

Employer Name____

Insurance Company Name____________________________ Ins. Co. Phone (____)___________

Ins. Co. Address____________________________ City______________ State_____ Zip_______

Secondary Dental Insurance

Insured Member: First Name_____________________ Last Name_________________________

Sex: ☐Male ☐Female Birth Date:____________ Soc. Sec. #__________________________

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other________________

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #__________________________ Group #___________________________

Employer Name____

Insurance Company Name____________________________ Ins. Co. Phone (____)___________

Ins. Co. Address____________________________ City______________ State_____ Zip_______

Primary Medical Insurance

Insured Member: First Name_____________________ Last Name_________________________

Sex: ☐Male ☐Female Birth Date:____________ Soc. Sec. #__________________________

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other________________

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #__________________________ Group #___________________________

Employer Name____

Insurance Company Name____________________________ Ins. Co. Phone (____)___________

Ins. Co. Address____________________________ City______________ State_____ Zip_______

Secondary Medical Insurance

Insured Member: First Name_____________________ Last Name_________________________

Sex: ☐Male ☐Female Birth Date:____________ Soc. Sec. #__________________________

Relationship to Patient: ☐Self ☐Spouse ☐Father ☐Mother ☐Other________________

Does your plan cover: ☐Dental ☐Medical ☐Both

Insured Member I.D. #__________________________ Group #___________________________

Employer Name____

Insurance Company Name____________________________ Ins. Co. Phone (____)___________

Ins. Co. Address____________________________ City______________ State_____ Zip_______

Patient Information & Health History – Page 3 Date: ____________

Patient Health History Form - Please complete the Health History so that we may provide the best possible care; the doctor will discuss the History with you prior to beginning treatment.

Patient's Name____ Date of Birth_________________

I. GENERAL INFORMATION

Sex: ☐Male ☐Female Height_________________ Weight_________________

Are you in good health? ☐Yes ☐No

Are you now under a physician's care for a particular problem? If so, describe:

____

____

Physician name and telephone#____

Date of last physical exam____

Has there been any change in your general health in the past year? If so, describe:

____

____

Have you ever had any serious illness? If so describe:

____

____

Have you been hospitalized or had surgery during the last 5 years? If so describe:

____

____

II. DO YOU HAVE OR HAVE YOU EVER HAD: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Cardiovascular disease? (heart attack, coronary artery disease, angina, chest pain, irregular heart rate or palpitations, congenital heart disease, rheumatic heart disease, murmur)
2. High blood pressure?
3. Stroke?
4. Heart surgery? (bypass or stent)
5. Pacemaker?
6. Respiratory disease? (asthma, emphysema, COPD, chronic cough, bronchitis)
7. Epilepsy or seizures?
8. Fainting or dizziness?
9. Bleeding disorder, anemia?
10. Blood transfusion?
11. Bruise or bleed easily?
12. Liver disease (jaundice, hepatitis)?
13. Kidney disease?
14. Diabetes (Type?)
15. Thyroid disease?
16. Arthritis?
17. Stomach ulcers or acid reflux (GERD)?
18. Other GI disease?
19. Glaucoma?
20. Osteoporosis?
21. Implants or joint replacements?
22. Radiation therapy?
23. Chemotherapy?
24. Sinus or nasal problems?
25. Seasonal allergies?
26. Snoring or sleep apnea?
27. Psychiatric illness?
28. Disease or medication that has depressed your immune system?
29. Organ transplant?

 Date: ____________

III. ARE YOU TAKING ANY OF THE FOLLOWING: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Antibiotics?
2. Anticoagulants or blood thinners (Coumadin, Plavix)?
3. Aspirin or ibuprofen?
4. Steroids (cortisone, prednisone, etc.)?
5. Tranquilizers, sleep aids, antidepressants, narcotics?
6. Insulin or oral anti-diabetic drugs?

Have you ever taken:

7. Diet pills?
8. Bisphosphonate bone density medications (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?
9. Have you ever been advised to not take a medication?
10. Please list ALL medications you are taking, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals (*please attach medications list if you run out of space*):
    ____
    ____
    ____
    ____
    ____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Local anesthesia (Novocain, etc.)?
2. Penicillin or other antibiotics?
3. Sedatives, barbiturates?
4. Aspirin or ibuprofen?
5. Codeine or other painkillers?
6. Latex or rubber products?
7. Chemicals or jewelry (rash or sensitivity)?
8. Food products? Soy? Eggs?
9. Other allergies or reactions? If so, please list:
   ____
   ____
   ____

V. FOR FEMALE PATIENTS ONLY

1. Please provide the date of you last menstrual period. ___________________
2. Are you pregnant, or is there any chance you might be pregnant? If so, when is your expected delivery date? _______
3. Are you nursing? _____________

If you are using Oral Contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.

VI. ADDITIONAL INFORMATION: PLEASE CIRCLE THE NUMBER IF THE ANSWER IS "YES"

1. Do you smoke or chew tobacco?
   How much?__________ For how long?_________
2. Is there any past history of alcohol or chemical dependency?
3. Is there any emotional or psychiatric illness that may affect the care we provide?
4. Have you had any serious problems associated with previous dental treatment?
5. Do you have pain, clicking or popping of the jaw joint, or difficulty opening mouth?
6. Do you grind or clench your teeth?
7. Have you or an immediate family member had any problem associated with anesthesia?
8. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
9. Do you wish to talk to the doctor privately about anything?

I understand the importance of a truthful and complete health history to assist the doctor in providing the best possible care. I have read and understand the above information.

DATE_______ PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR)______________________________________

 Date: ____________

Welcome to Our Practice

Drs. Benninger, Schween, & Schmidt are pleased to welcome you to our practice. We look forward to providing you with the most modern oral surgery care available.

Financial Arrangements (Self-Pay and Insurance Patients)

We require payment in full at the time of service for anything not covered by an insurance company. This amount is your responsibility. We accept Cash, Checks, VISA, MasterCard, Discover, and Care Credit.

Insurance Instructions (Insurance Patients Only)

We file your insurance claims as a courtesy to you. Professional services are rendered and charged to you, not the insurance company. Please understand that the contract is between you and the insurance company, and payment for the services is *your* responsibility. We do not determine the amount of coverage you will receive. Your insurance company makes this determination. Any questions you may have concerning your insurance benefits should be directed to your insurance representatives. We will be happy to submit your claim for you. We reserve the right to refuse assignment of benefits for some insurance plans.

At the time of service, we will call your insurance company and get an "estimated payment" for the services rendered. The "estimated" portion that the insurance company does not pay is required at the time of service, in full. After your insurance pays, you will be billed for the amount that differs from the estimate that was made at the time of service. Should the insurance company pay more than anticipated, we will issue a refund check to you.

If we are accepting assignment of benefits (payment from your insurance company), you are required to sign the following statement prior to the appointment, even if your appointment is for a consultation:

I hereby authorize payment of benefits directly to Medina Oral Surgeons.

X ____
Signed (Patient OR Parent/Guardian if Minor)

I understand that I will be receiving a treatment plan with associated fees. I agree to be responsible for all charges for services and materials not paid by my insurance. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I HAVE READ AND UNDERSTAND THE STATEMENTS OUTLINED ABOVE IN THE FINANCIAL ARRANGEMENTS AND/OR INSURANCE INSTRUCTIONS SECTIONS.

X ____ ____________________ __________________
Signed (Patient OR Parent/Guardian if Minor) Relationship to Patient Date

 Date: ____________

Dr. Richard M. Benninger, Dr. Gary R. Schween, and Dr. Brian P. Schmidt
Notice of Privacy Practices

This following notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us. Please review it carefully. The notice can be downloaded and printed, or viewed online, here:

http://www.medinaoralsurgeons.com/hipaa-privacy-policy

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____(please print full name), HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES, AND HAVE BEEN OFFERED A COPY OF SUCH POLICY TO KEEP FOR MY RECORDS.

_____ (PLEASE INITIAL HERE), I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A COPY OF THE POLICY.

-OR-

_____ (PLEASE INITIAL HERE), I HEREBY REFUSE TO ACKNOWLEDGE RECEIPT OF THE POLICY. I UNDERSTAND THAT EVEN THOUGH I MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT, I WILL STILL BE PROVIDED TREATMENT.

____ ______________________________
(SIGNATURE) PATIENT OR LEGAL REPRESENTATIVE (DATE)

****

I, ____(please print full name) AUTHORIZE THE OFFICE OF DRS. BENNINGER, SCHWEEN, AND SCHMIDT TO DISCUSS MY HEALTH AND/OR ACCOUNT INFORMATION WITH THE FOLLOWING PEOPLE:

SPOUSE: ____

CHILDREN: ____

PARENT: ____

OTHER: ____

____ ______________________________
(SIGNATURE) PATIENT OR LEGAL REPRESENTATIVE (DATE)