SUMMIT
Oral & Maxillofacial Surgery

PATIENT INFORMATION

Name: ______________________ Birthdate: __________ Sex: ____ Marital Status: ________
Address: ______________________________________ Weight: __________
Mailing Address: *If different* ______________________________________
City: __________________ State: ________ Zip:__________ SS#:__________________
Home Phone: (______)__________________ Cell Phone:_(________)__________________
Employer or School Name: ______________________ Work Phone: ______________
Dentist:______________Orthodontist:______________Physician:______________
Whom may we thank for Referring you:__________________ Physician #:______________

PERSON RESPONSIBLE FOR PAYMENT ***Same*** ***Parent*** ***Guardian*** ***Other***

Name:__________________Birthdate:__________________ SS#______________
Address: ______________ City: ______________ State: ________ Zip:__________
Home Phone: ____________ Work Phone: ____________Cell Phone: ______________
Employer: ____________________ Email Address: ______________________

INSURANCE INFORMATION

Primary Dental
Insurance Co. ______________________
Address ______________________
Insurance Co. Phone ( ) ______________________
Insurance ID # ______________________
Group #______________________
Policyholder ______________________
Sex c M c F
Social Security______/_______/______
Date of Birth ______/_______/_______
Address ______________________
____
Relationship to Patient ______________________
Subscriber's Employer ______________________

Secondary Dental
Insurance Co. ______________________
Address______________________
Insurance Co. Phone ( ) ______________________
Insurance ID # ______________________
Group #______________________
Policyholder ______________________
Sex c M c F
Social Security______/_______/______
Date of Birth ______/_______/_______
Address ______________________
____
Relationship to Patient ______________________
Subscriber's Employer ______________________

MEDICAL INSURANCE

Medical Insurance Company: ____________________ ID Number: ____________________
Mail Claims to: ____________________ Phone#: ____________________
Subscriber's Name: ____________________ ___ Date of Birth ______/_______/_______
Social Security______/_______/______ Relationship: ____________________

IF YOU ARE HAVING SURGERY TODAY

Have you had any thing to eat or drink in the last 6-8 hours? Yes No **Time:** ____________
Who is driving you home? ______________________________
Is there any condition concerning your health that the Dr. Egbert should be told about? Yes No
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Is there a FAMILY HISTORY Of: ***Cancer*:** Yes No ***Diabetes:*** Yes No ***Heart Disease:*** Yes No ***Anesthetic Problems*:** Yes No

THIS SECTION IS FOR WOMEN

	Due Date:	Yes	No
Is there a possibility you may be/are pregnant	Due Date:		
Are you taking birth control			
Are you nursing			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional methods of birth control.

HEALTH HISTORY

Have you had or do you have:	Yes	No	Notes:	*Have you had or do you have:*	Yes	No	Notes:
Rheumatic Fever				Diabetes			
Damage heart valves				Low blood sugar			
Heart murmur				Arthritis or joint disease			
High blood pressure				Osteoporosis/Osteopenia			
Low blood pressure				Stomach ulcers			
Chest pain/angina				Delay in healing			
Heart surgery				Cancer/Radiation			
Heart attack				Mental Health Issues			
Cardiac pacemaker				Eye disease/surgery			
Pneumonia, chronic cough				Sexually transmitted disease			
Epilepsy/Seizures							
Asthma				History of drug abuse			
Hay fever/sinus problems				History of alcohol abuse			
Snoring/sleep apnea				Hepatitis A B C			
Lung problems				Liver Disease			
Tuberculosis/ Emphysema				HIV AIDS			
Anemia				Blood disorder			
Bleeding tendency				Do you chew tobacco			
Blood transfusion				Do you smoke			

MEDICATIONS	Yes	No	Notes:	**ALLERGIES**	Yes	No	Notes:
Sleeping medications				Local anesthetic			
Natural or herbal supplements				Penicillin Amoxicillin			
Have you ever taken diet pills				Sulfa drugs			
Do you take Blood thinners				Other antibiotics			
Have you ever taken any bone density medication Bisphosphonates? Actonel, Aredia, Zometa, Fosamax				Codeine or any other narcotics			
Are you on a pain contract				LATEX			
Are you taking any medications			**LIST BELOW**	SOY			
Do you have a list of your medications			***IF YES DO NOT LIST.***	EGGS			
PLEASE LIST ANY RX'S YOU ARE TAKING				**PLEASE LIST ANY OTHER ALLERGIES**			
DO YOU NEED TO PREMEDICATE	**YES**	**NO**		**DO YOU WEAR CONTACTS**	**YES**	**NO**	

HAVE YOU HAD ANY SURGERIES? Yes No ***** IF YES PLEASE LIST***

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TMJ/JAW PAIN

TMJ/JAW PAIN	Yes	No
Do you have migraine/tension headaches		
Does your jaw ache when you chew		
Does you jaw pop or click when you open or close		
When are your symptoms worse		
Have you ever had any trauma to the face or jaw		

AUTHORIZATION

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

__________ (initials)

HIPPA

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. I hereby acknowledge that a copy of the Privacy Practices has been available to me for review, I have been given the opportunity to ask any question I may have regarding this notice. ***No cell phone use allowed in operatory or recovery area. No cell calls, photos and/or videotaping/recording. This is due to the HIPPA confidentiality regulations. Thank you for your cooperation and respect for our patients and employees privacy.***

If you are 18 and older, Please add any family that we have permission to speak to about your treatment, appointments, financials, etc..

__________ (initials) | ______________________ OK to Speak to: Please Print | ______________________ OK to Speak to: Please Print

FEES AND PAYMENTS

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I fully understand that the office can only give an ESTIMATE and is not responsible for my insurance not covering all surgery fees.

By signing below I agree to pay all amounts owed with in 30 days of when such amount (s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount is/are referred to a third debt collection agency, I agree that in addition to any other amount(s) is/are allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee for up to 40 % of the principal amount(s) owing as allowed by Utah Code Annotated, sec 12-1-11. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. *

Signature of Patient (parent or guardian) X______________________ **Date:** X______________

Doctor : X______________ **Witness:** X______________ **Date:** X______________