Plateau Oral & Facial Surgery

Patient Information

First Name	MI	Last Name	Gender	Date of Birth	Age	Height	Weight	Date

Nick Name: ______________________ Social Security #.: ______________________ Driver's License #: _____________________
Street Address: ____ City: ___________________ State: ________ Zip: ___________
Home Tel.: (_____) _______________ Bus. Tel.: (_____) ________________ Ext: _____Cell No.: (________) _________________
Physician: ____________________________ Dentist: ____________________________ Referred By: __________________________
Have you or anyone in your family ever been in our office before? No ___Yes ___ Who? ___________________________________
Employed / Retired / Not Occupation: ____
Student: Full / Time/Part / Time /Not School Name: ____
Hobbies / Interests: ____
Responsible Guardian for care and account? Relation: ↑Self ↑Spouse ↑Mother ↑Father ↑Other: ___________________________
Name: ________________________ Soc. Sec. #: _______________ Home Tel: (___)_____________Cell No. (____)_____________
Street: ____ City: ___________________ State: ___________ Zip: __________
Is this your emergency contact? ↑Yes ↑No If no, please list emergency contact here: ___________________________________
Relation: ______________ Name: _________________________ Home Tel: (______)___________ Cell No.: (______)___________

Acknowledgement of Non participation with Medicare / TriCare Non-Covered Services /Receipt of HIPAA Privacy

By signing this contract I understand and agree that I will not submit (or request that my oral and maxillofacial surgeon submit) a claim to Medicare, or its agents for services provided by Cortland S. Caldemeyer DDS, even if such services would otherwise be covered. I agree to be fully responsible, through insurance or otherwise, for payment of services rendered by Cortland S. Caldemeyer DDS, and I understand that no claims will be submitted to Medicare, and no Medicare, reimbursement will be provided for these services. I understand that there are no limits specified by Medicare, as to the amounts that may be charges by the oral and maxillofacial surgeon for services provided. I understand that Medi-gap plans do not, and other health and medical care insurance plans may elect not to, make payments for such services. I understand that I have the right to have services provided by other oral and maxillofacial surgeons, or other practitioners for whom Medicare payment would be made, and that I am not compelled to enter into private contracts that apply to covered care furnished by other health care professionals who have not opted-out. I understand that Cortland. S. Caldemeyer DDS is not excluded from participation in the Medicare program under Section 1128 or the Social Security Act or pursuant to any other legal authority.

I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy, which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service. I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services.

I understand this notice will serve as acknowledgement of my non-participation with Medicare, or Tricare non-covered services for all of my visits to Plateau Oral & Facial Surgery.

I acknowledge that I have been given access to, and reviewed the HIPPA privacy compliance policy of Plateau Oral & Facial Surgery Center to my satisfaction. I understand a copy of the policy is available should I request it.

Health History

Please Circle Any of the Following Which You Currently Have or Have Had □**See Attached Sheet**

Rheumatic (Scarlet) Fever	Heart Surgery	Chest Pain	Bleeding Tendency	Parkinson's	Cancer Where? ______________	Snore
Rheumatic Heart Disease	Stent	Pneumonia	Gastrointestinal Disease	Seizures	Radiation Where? ______________	Sleep Apnea
Congenital Heart Disease	Pacemaker	Shortness of Breath	Ulcers	Convulsions	Chemotherapy / Anti-Metastatic (Spreading) Drugs	Portable Catheter
Heart Attack	Defibrillator (AICD)	Tuberculosis	Colitis	Epilepsy	Difficulty Opening Mouth	Vision Problems
Heart Failure	Abnormal Heart Rhythm	Liver Disease	Acid Reflux	Fainting of Dizziness	Pain Near Ear	Glaucoma
Heart Murmur	Heart Valve Replacement	Jaundice	Genitourinary Disease	Alzheimer's Disease	Grind of Clinch Teeth	Eye Surgery
Mitral Valve Prolapse	Shortness of Breath	Hepatitis A / B / C	Endocrine Disease	On a Diet	Sinus or Nasal Problems	Contact Lens
Coronary Artery Disease	Lung Disease	Bleeding Disorder	Thyroid Disease	Arthritis	Hay Fever	Venereal Disease
Angina	Asthma	Blood Disorder	Diabetes I / II	Rheumatism	Leukemia	Kidney Disease
High / Low Blood Pressure	Emphysema	Anemia / Sickle Cell	Herpes	Osteoporosis	HIV / AIDS	Kidney Failure / Dialysis
Heart Palpitations	COPD	Blood Transfusion	Cold Sores	Implants Hip / Knee / Other	Transplant / Transplant List? ______________	Chronic Headaches
Stroke	Cough	Bruise Easily	Neurologic Condition	Abnormal Swelling	Immunosupression	Malignant Hyperthermia
Pain Pump	Developmental Disorder ___________	Recreational Drug Use Alcohol / Chemical ___________	Bipolar / Schizophrenia / Emotional Disorder	Smoke or Smokeless Tobacco How Much? _________	Alcohol How Much? ______________	Family Anesthesia Problems

Do you have any diseases, conditions, or problems not listed above, been hospitalized or had any surgeries? **Yes** **No**
If yes, please explain:

____
____
____
____

Do you need to be pre-medicated with antibiotics for dental procedures? **Yes** **No** Have you ever? **Yes** **No**
If yes, please explain:

____
____

Are you taking or ***have you ever taken*** Bisphosphonates or anti-angiogenesis medicines for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? **Yes** **No** If yes, how long?

____
____

For Women Only

Are you Pregnant, or **is there any chance** you might be Pregnant? **Yes** **No** Are you Nursing? **Yes** **No**

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. 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. Please consult with your physician for further guidance.

Allergies: Please list any known allergies to food or medications. Include any Penicillin, Sulfa drugs, Local Anesthesia, Aspirin, Iodine, Latex, Egg, pain or sedative medicines with the Reaction. □ **See Attached Sheet**

Allergy □ **None** □ **See Attached Sheet**	**Reaction**

Medicines: Please include ALL medications you are currently taking. Include Prescription Drugs, Diet/Weight Loss Medicines, Blood Thinners, Birth Control, Osteoporosis, Cancer Medications, Immunosuppressive Drugs, Over the Counter Pain Medicines, Herbal/Holistic Remedies, Vitamins, Supplements & Minerals. □ **See Attached Sheet**

____
____
____
____
____
____

I understand the acknowledgements as well as the importance of a truthful and complete Health History to assist my surgeon in providing the best care possible. If I have not completed the list, I have completed it to the best of my ability, and unable to provide any further unknown information. I also give my consent for my surgeon to obtain any medical records or laboratory tests deemed pertinent my evaluation and treatment. This signature on file is my authorization for the release of information necessary to process my claim and I hereby authorize payment directly to the Plateau Oral & Facial Surgery of the insurance benefits otherwise payable to me.

Date   Signature of Patient/Guardian Completing Health History   Doctor's Initials

PLEASE EDIT HEALTH HISTORY IF THERE HAS BEEN ANY CHANGES AND RESIGN, OR RESIGN TO VERIFY THAT THERE HAS BEEN NO CHANGES IF YOUR HEALTH HISTORY.

Date   Signature of Patient/Guardian Completing Health History   Doctor's Initials

Date   Signature of Patient/Guardian Completing Health History   Doctor's Initials

Date   Signature of Patient/Guardian Completing Health History   Doctor's Initials

Date   Signature of Patient/Guardian Completing Health History   Doctor's Initials