Welcome to Blum-Nico Oral Surgery Associates

www.BlumNico.com

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Aventura
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T: (305) 936-5974

Patient's Name: (Mr., Mrs., Ms., Dr.) _____ _____ Today's Date: _____
Last First MI

Marital Status: Single___ Married___ Divorced___
Age:____ Birthdate:_____ Sex: Male___ Female___
Home Phone: _____
Work Phone: _____**Cell Phone:**_____
E-mail: _____
How would you like us to confirm your appointment?
Telephone___ Email___ Text Message___
Driver's Lic/S.S. #: _____
Address: _____
City:_____ **State:**_____ **Zip:**_____
Present Complain:_____
Who referred you to this office?
_____
Dentist: **Phone:**
_____
Physician: **Phone:**
_____

Contact Person (not living with you) **Phone:**
_____
Who is responsible for this account?
_____
Patient/Parent employed by:
_____
Employer's address: **Phone:**
_____

Medical Insurance Coverage Information:
Insured's Name: _____
Date of Birth:_____ **Social Sec. No.** _____
Name of Insurance Co. _____
Plan/ID No.:_____
Dental Insurance Coverage:
Insured's Name: _____
Date of Birth:_____ **Social Sec. No.** _____
Name of Insurance Co. _____
Plan/ID No.:_____
Method of Payment:
Insurance__ Credit Card__ Cash/Check__ Other___

1. Are you in good health?..... Yes No
2. Has there been any change in your general health in the past year? ……..…….... Yes No
3. Are you under the care of a physician?..... Yes No
   If yes, for what? _____ Date of last Visit:_____
4. Have you had any illnesses, operations or hospitalizations?..... Yes No
   If yes, describe:_____
5a. Have you ever been told that you need to premedicate before any dental treatment?..... Yes No
5b. Have you ever or do you currently take medications for the treatment of osteoporosis?
   For example Zometa, Reclast, Boniva, Actonel, Prolia, Xgeva, Evenity, Alendronate, Fosamax……..... Yes No

PLEASE ANSWER ALL QUESTIONS BY CHECKING YES OR NO All answers are kept confidential

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO		HAVE YOU HAD OR DO YOU CURRENTLY HAVE…	YES	NO
6.	Rheumatic fever?			**14.**	Seizures, convulsions, epilepsy, fainting spells, psychiatric treatment, dizziness, nervous disorder or breakdown?		
7.	Congenital heart disease?						
8.	Heart murmur?			**15.**	Diabetes?		
9.	Cardiovascular disease (heart trouble, heart attack, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pace maker?			**16.**	Liver disease or jaundice?		
				17.	Kidney disease or dialysis?		
10.	Are you taking any medications if so? Please list: _____ _____			**18.**	Thyroid disease?		
				19.	Arthritis?		
				20.	Stomach ulcers or colitis?		
11.	Do you have allergies or ever had any allergic reactions? If so please list _____ _____			**21.**	AIDS HIV, delay in healing, or any reason to be immunosuppressed?		
				22.	A tumor, growth, X-Ray treatment or chemotherapy?		
12.	Lung disease (asthma, emphysema, chronic Cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?			**23.**	Contact lenses?		
				24.	Any sinus problems?		
13.	Do you smoke?			**25.**	Eye disease or glaucoma?		

		YES	NO			YES	NO
26.	A removable dental appliance?			**30.**	Do you have any bleeding disorders? If yes, please specify_____		
27.	Pain and clicking of jaws when eating?			**31.**	Do you have any other disease, condition or problem that the doctor should know about? If so, please specify_____		
28.	A history of Alcohol, cocaine, marijuana or others? _____			**32.**	Do you wish to talk with the doctor privately about anything? _____ _____		
29.	Malignant hyperthermia?						

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided here is complete and accurate.

Patient/Guardian's Signature_____Date_____

FOR WOMEN ONLY

A. If you are using oral contraceptives it is important that you understand that antibiotics and 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 medications s completed. Please consult with your physician for further guidance.

B. If you are pregnant, possibly pregnant, or trying to become pregnant, surgery, anesthetics or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant.

1.Are you pregnant or planning pregnancy?..... Yes No
2.Are you taking any birth control pills? ..... Yes No
3.Are you taking hormone replacements? ..... Yes No

Signature _____

CONSENT AND RELEASE OF RECORDS

____The information, both on this page and on the medical history, are correct to the best of my knowledge. I authorize the doctors from Blum-Nico Oral Facial Surgery Associates and their designated staff, to perform an oral and maxillofacial examination and take x-rays as required for the purpose of diagnosis and treatment planning. Furthermore, I authorize the release of any records from my medical doctor, dentist, or specialist needed for diagnosis and treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

CONSENT TO USE RECORDS

____I hereby give permission for the use records including photographs taken during the examination(s), treatment, and retention for the purposes of professional consultations, research, education, or publication in professional journals. I consent to the taking of photograph(s) and video(s) of the undersigned which may be reproduced and/or used in any and all advertisement or promotional purposes for the above doctor(s) and practice, including but not limited to websites, Facebook, Twitter, and other social media. In giving this consent, I release the above practice and doctor(s) from liability for any violation of any personal or proprietary right I may have in connection with such photograph/video reproduction or use.

FEES AND PAYMENTS

____Thank you for choosing our office for your oral surgery care. Any fees or payments are due the date of service. Payment arrangements can be made depending on special circumstances at the discretion of our office. An estimate of the charge for any surgical procedure can be given upon request. A finance charge (18% annually) will be added to any balance over 30 days. I further agree that I will be responsible for all collections costs, attorney's fees and court costs. Please remember that insurance is considered a method of reimbursing the patient for fees paid to doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures while others pay a percentage of the charge. If you have any dental and/or medical insurance we will be glad to fill out the proper forms you. Please complete the identifying information on this form. The signature below on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named in the benefits, or otherwise payable to me.

Signature: _____Date: _____

Witness: _____Date: _____

Doctor's Signature: _____Date: _____