WESTSIDE ORAL SURGERY, PC

Christopher J. Larmour, DMD
Board Certified

Practice Limited to Oral and Maxillofacial Surgery

PATIENT REGISTRATION

Today's Date _____ **BIRTHDAY** _____ Sex _____

Patient's name _____ **SS#** _____
LAST FIRST M.I.

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cellular Phone _____ Business Phone _____

Patient Employed By _____ How Long? _____

Employer's Address _____ Work Phone _____

Who is financially responsible? (If not the patient) _____ **BIRTHDATE** _____ **SS#** _____

Relationship to Patient? _____ Home Phone _____

Home Address _____

Employer's Name and Address _____ Work Phone _____

Whom may we thank for your referral? _____ Email _____

INSURANCE INFORMATION

Prior to treatment, does your insurance require a Pre-Authorization? ❑ YES ❑ NO

DENTAL INSURANCE	MEDICAL INSURANCE
Insurance Co. _____	Insurance Co. _____
Employer _____	Claims Address _____
Policy Holder's Name _____	Employer _____
Policy Holder's Birthdate _____	ID# _____
Policy Holder's SS# _____	Group# _____
SECONDARY DENTAL	**SECONDARY MEDICAL**
Insurance Co. _____	Insurance Co. _____
Employer _____	Claims Address _____
Policy Holder's Name _____	Employer _____
Policy Holder's Birthdate _____	ID# _____
Policy Holder's SS# _____	Group# _____

HEALTH HISTORY

Please Note — All information is held in strict confidence.

Referring Dentist _____ Phone # _____

Referring Orthodontist _____ Phone # _____

Family Physician _____ Phone # _____

What brings you to our office today? _____

Emergency Contact _____ Phone # _____

Are you presently under a physician's care? ❑ YES ❑ NO

If Yes, what is the condition being treated? _____

***Have you taken aspirin within the last 7 days? ❑ YES ❑ NO**

Are you taking or have you ever taken Actonel, Fosamax, Reclast, or Prolia? ❑ YES ❑ NO

Please list all medications you are now taking:

Medication	Dosage	Why

LIST ALL MEDICATIONS OR FOODS YOU ARE ALLERGIC TO:

❑ Penicillin ❑ Sulfa ❑ Aspirin

❑ Codeine ❑ Novacaine ❑ Latex

❑ None

Others _____

HABITS – AMOUNTS

Smoke? ❑ YES _____ Packs ❑ NO

Alcohol? ❑ YES _____ Per day ❑ NO

Drug Use? ❑ YES _____ ❑ NO

Have you ever had a problem with drugs or alcohol? ❑ YES ❑ NO

Others _____

You're Almost Through: Please Turn Over and Complete Side Two

HEALTH HISTORY – Cont'd

Please Check Yes or No

GENERAL	YES	NO
Tire easily, Weakness	❑	❑
Marked Weight Change	❑	❑
Persistent Fever	❑	❑
"Have Taken Weight Loss Products (e.g. Phen-Phen)	❑	❑

SKIN		
Rashes, Hives	❑	❑
Changes in Skin Color	❑	❑

EYES		
Eye Problems	❑	❑
Glaucoma	❑	❑

EARS		
Loss of Hearing	❑	❑
Ear Infection	❑	❑ s

NOSE		
Frequent Nose Bleeds	❑	❑
Sinus Problems	❑	❑

THROAT		
Frequent Sore Throat	❑	❑
Post Nasal Drip	❑	❑
Cleft Palate	❑	❑

ENDOCRINE		
Diabetes	❑	❑
Thyroid Problems	❑	❑
Other Gland Problems	❑	❑

NERVOUS SYSTEM	YES	NO
Stroke	❑	❑
Frequent Headaches	❑	❑
Convulsions/Epilepsy	❑	❑
Numbness/Tingling	❑	❑
Dizziness/Fainting	❑	❑
Nerve Problems	❑	❑
Head Injury	❑	❑
Psychiatric Treatment	❑	❑
Emotional Problems	❑	❑

CARDIOVASCULAR		
Mitral Valve Prolapse	❑	❑
Rheumatic Fever	❑	❑
Any Heart Disease	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Chest Pain/Discomfort	❑	❑
Congenital Heart Disease	❑	❑
Artificial Heart Valve	❑	❑
Pacemaker	❑	❑
Scarlet Fever	❑	❑
Heart Surgery	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑

RESPIRATORY		
Asthma	❑	❑
Emphysema	❑	❑
Bronchitis	❑	❑
Pneumonia	❑	❑
Persistent Cough	❑	❑
Sleep Apnea	❑	❑

MUSCULOSKELETAL	YES	NO
Arthritis/Rheumatism	❑	❑
Broken Bones	❑	❑
Artificial Joints/Pins/Parts/Implants	❑	❑
Osteoporosis/Osteopenia	❑	❑

DIGESTIVE		
Changes in Appetite	❑	❑
Black, Bloody or Pale Stools	❑	❑
Jaundice	❑	❑
Hepatitis	❑	❑
Stomach Ulcers	❑	❑
Liver Disease	❑	❑

URINARY		
Kidney Disease	❑	❑
Kidney Transplant	❑	❑
Venereal Disease	❑	❑
Other	❑	❑

BLOOD		
Bleeding Problems	❑	❑
Blood Disorder	❑	❑
Sickle Cell	❑	❑
Anemia	❑	❑
HIV	❑	❑
Other	❑	❑

OTHER		
Radiation Treatment	❑	❑
Tumors/Growths	❑	❑
Cancer	❑	❑
Tuberculosis	❑	❑

All Operations or Surgeries: Year

_____

_____

Is there anything else you feel we should know about? _____

_____

_____

_____

FAMILY HISTORY	YES	NO
Cancer	❑	❑
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Sickle Cell	❑	❑

WOMEN ONLY

ARE YOU PREGNANT NOW? ❑ YES ❑ NO ❑ MAYBE

ARE YOU TAKING THE BIRTH CONTROL PILL? ❑ YES ❑ NO

ARE YOU CURRENTLY BREAST FEEDING? ❑ YES ❑ NO

IMPORTANT: Antibiotics (Penicillin, Erythromycin, etc.), which may be prescribed after treatments, may cause the birth control pill to be ineffective. Other methods of contraception are recommended for the duration of the affected cycle.

Nearest Relative Not Living With You

_____

Address_____

_____

_____

Phone_____

A NOTE OF THANKS:

Thank you for taking the time to provide us with your health history and insurance information. We are glad you chose our office for your current needs. Our friendly staff will help you relax and inspire your confidence in having made the right choice to come here. All treatments use the latest and safest technology available. Be assured we will provide you with the best care and lots of TLC. We hope you'll be pleasantly surprised.

I am 18 years of age or older, and to the best of my knowledge all the preceding answers are true and correct.:

Signature:_____

Sincerely,

The Doctors & Staff of
WESTSIDE ORAL SURGERY, PC

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY _____ DATE _____

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____ YES	_____ NO
DO YOU HAVE A FEVER?	_____ YES	_____ NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____ YES	_____ NO
DO YOU HAVE A DRY COUGH?	_____ YES	_____ NO
DO YOU HAVE A RUNNY NOSE?	_____ YES	_____ NO
DO YOU HAVE A SORE THROAT?	_____ YES	_____ NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____ YES	_____ NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____ YES	_____ NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____ YES	_____ NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____ YES	_____ NO

IF SO, WHERE? _____

Westside Oral Surgery
Dr. Christopher Larmour

9101 High Assets Way, Suite 101, Albuquerque, NM 87120 (505-899-6979)

Thank you for choosing our team for your dental care. We are looking forward to helping you with your oral surgery needs; we appreciate the trust you have placed in us. **Our office policies and procedure are designed to keep you informed.** All our patients must complete and sign our New Patient form prior to any treatment. We ask that you sign this form after you have read it.

PAYMENT ARRANGEMENTS

WE GLADLY ACCEPT CASH OR CREDIT CARDS
(Visa, MasterCard, Discover, CareCredit)
NO CHECKS ACCEPTED

Full payment is due at the time of service. **We require ½ down to hold your surgery appointment time for you.**
_____Initial

REGARDING INSURANCE

We emphasize that as dental care providers, our relationship is with you, not your insurance company. Your insurance policy is a contract between you and the insurance company. We are not a party on that contract. In the event we accept assignment of benefits, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. If your insurance company has not paid within sixty (60) days, and all efforts to collect from them have been exhausted, the unpaid balance will become your liability and you will be responsible for payment regardless of any insurance company's arbitrary determination of the unpaid services. There is a fee for the consultation and as a courtesy we will file a claim with your insurance. If it is denied you will be billed the remaining balance. _____Initial

MINOR PATIENTS

A parent or legal guardian must accompany all minor patients. Please do not leave your children unattended. OSHA standards do not permit unattended children, so please make arrangements to have an adult stay with them during the entire dental appointment time.

MISSED APPOINTMENTS

If you cannot keep your scheduled appointment we require that you give us the courtesy of 48 hour notice. There will be a $25.00 to $75.00 charge for missed or broken appointments without at least a 24 hour notice.

Thank you for reading and signing our policies. Please let us know if you have any questions or concerns.

I have read the policies. I _____, understand and agree to the above statements.
(print full name)

Signature:_____ Date:_____
(Patient, Parent or Legal Guardian)

Westside Oral Surgery

9101 High Assets Way, Ste 101
Albuquerque, NM 87120
505-899-6979

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have been informed of this office's Notice of Privacy Practices.

Print Name _____ Address _____

Signature (Patient or Legal Guardian) _____ Date _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____
2. _____
3. _____
4. _____
5. _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) _____