Mountainside
Oral & Maxillofacial Surgery

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# AARON U. ADAMSON, DMD

**BOARD CERTIFIED ORAL & MAXILLOFACIAL SURGEON**

## PATIENT INFORMATION FORM

Mr. Mrs. Ms. Dr. (circle one)

First Name: _____ MI: _____
Last Name: _____
Nickname: _____
Sex (M) _____ (F) _____
Date of Birth: _____ Age: _____
SSN#: _____
Student Yes _____ No _____
School Name _____

Email Address: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone #: Home: _____
Cell: _____
Work: _____
Physician: _____
Dentist: _____
Orthodontist: _____
Employer: _____
Occupation: _____

### GUARANTOR INFORMATION (RESPONSIBLE PERSON):

First Name: _____ MI: _____
Last Name: _____
DOB: _____
SSN#: _____
Employer: _____
Dental Insurance: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone #: Home: _____
Cell: _____
Relation to pt: _____Self; _____Spouse; _____Parent
Medical Insurance Company: _____

### SECONDARY GUARANTOR INFORMATION:

First Name: _____ MI: _____
Last Name: _____
DOB: _____
SSN#: _____
Employer: _____
Dental Insurance: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone #: Home: _____
Cell: _____
Relation to pt: _____Self; _____Spouse; _____Parent
Medical Insurance Company: _____

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Adamson to release any information acquired in the course of my examination treament to my referring dentist/physician or my insurance company.

### AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment of the medical/dental benefits to Dr. Adamson for his service. I understand that I am financially responsible for the charges not covered by this authorization. In the event the insurance company issues a check to me for unpaid services, I understand it is my financial responsibility to forward insurance payment to Dr. Adamson within 15 days of receiving payment. I also agree that any balance remaining for more than ninety (90) days shall accrue interest at one and one half percent (1 1/2%) per month until paid in full. A copy of this authorization shall be valid as the original. I understand that if my account is assigned to a Collection Agency, the Collection Agency will charge a commission or fee that may be as much as 50% of the amount I owe Dr. Adamson. I agree that if my account is assigned to a Collection Agency, that Dr. Adamson's office may add the amount of the Collection Agency's commission or fee to the amount that I owe Dr. Adamson, and I agree to pay that additional amount.

*****COPY OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION AVAILABLE UPON REQUEST*****

_____ _____
**SIGNATURE** **DATE**

**PLEASE TURN THIS FORM OVER AND COMPLETE HEALTH HISTORY**

Please answer all questions by circling yes (Y) or no (N)

All responses are kept confidential.

1. Are you in good health? Y N
2. Have there been any changes in your general health in the last year? Y N
3. Date of last physical exam _____
4. Are you under a physician's care? Y N

   What For? _____
5. Have you ever had any serious illness, operations, or hospitalizations? If so, describe: Y N

   _____

   _____

   _____
6. Do you have or have you ever had:
   - A. Rheumatic Fever or rheumatic heart disease? Y N
   - B. Congenital heart disease? Y N
   - C. Cardiovascular disease (stroke, heart murmur, mitral valve prolapse, high blood pressure, angina, palpitations, coronary artery disease, pacemaker, heart attack, heart surgery, angioplasty)? Y N
   - D. Lung disease (asthma, emphysema, shortness of breath, tuberculosis, chronic chest pain, pneumonia)? Y N
   - E. Seizures, convulsions, epilepsy, fainting, dizziness? Y N
   - F. Bleeding disorder, anemia, blood transfusion, bleeding tendency, leukemia, bruise easily, excessive bleeding after tooth extraction? Y N
   - G. Liver disease, jaunice, hepatitis, cirrhosis? Y N
   - H. Kidney disease? Y N
   - I. Diabetes? Y N
   - J. Thyroid disease (goiter)? Y N
   - K. Arthritis? Y N
   - L. Stomach ulcers, hiatal hernia, colitis, acid reflux? Y N
   - M. Glaucoma, eye disease? Y N
   - N. Sinus or nasal problems? Y N
   - O. Frequent or recurring mouth sores? Y N
   - P. Clicking or popping of the jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
   - Q. Implants placed anywhere in your body (heart valve or stent, hip, knee, vessel graft)? Y N
   - R. Cancer? Y N
   - S. Radiation (X-Ray treatment for cancer? Y N
   - T. Recurrent infections of any kind? Y N
   - U. Any disease, drugs or transplant operation that has depressed your immune system? Y N
7. Are you taking any of the following:
   - A. Prilosec or acid reflux medication? Y N
   - B. Thyroid medications? Y N
   - C. Anitbiotics or sulfa drugs? Y N
   - D. Anticoagulants (blood thinners)? Y N
   - E. High blood pressure medicine? Y N
   - F. Digitalis, Inderal, Nitroglycerin, calcium channel blockers, Procardia or other heart medicine? Y N
   - G. Aspirin or Ibuprofen, Motrin, Naproxen, etc.? Y N
   - H. Steroids (Prednisone, Cortisone, etc.)? Y N
   - I. Tranquilizers (Valium, Prozac, Zoloft, Xanax, etc.)? Y N
   - J. Insulin, Metformin, or similar diabetic drugs? Y N
   - K. Antihistamines or decongestants? Y N
   - L. Are you taking any other regular medications, pills or drugs? If yes, please list: _____ Y N

     _____

     _____
8. Are you allergic or had a bad reaction to:
   - A. Local anesthetic (Novocaine, Xylocaine, etc.)? Y N
   - B. Penicillin, Amoxicillin, Keflex, Erythromycin, or other antibiotics? Y N
   - C. Valium, barbiturates, sedatives, etc.? Y N
   - D. Aspirin, Ibuprofen, Tylenol? Y N
   - E. Demerol, Codeine, or other pain killers? Y N
   - F. Other allergies or reactions? If yes, please list: Y N

     _____

     _____
9. Do you smoke or chew tobacco? Y N

   If so, how much daily? _____
10. Do you use alcohol? Y N

    If so, how much daily? _____
11. Do you use or have you used marijuana or other street drugs? If so, how much? _____ Y N
12. Have you ever sought professional care for or have a history of drug abuse or alcoholism? Y N
13. Have you ever been treated for emotional problems (depression, breakdown, nervous disorder, psychiatric treatment, personality disorder)? Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
15. Women: Are you pregnant or planning pregnancy? Y N
    - A. Are you taking birth control? Y N

I understand the importance of a truthful health history to assist the doctor in providing the best care possible.

| Date | Signature of person completing health form | Dr's Initials |
|---|---|---|

Health History Update:

| Date | Patient's Signature | Changes or exceptions to above history | Dr's Initials |
|---|---|---|---|