Florida Oral Surgery
Chuck DeWild, DMD, MD
205 Bellagio Circle Sanford, FL 32771
Phone: 407-330-3250 | Fax: 407-330-3209
www.flaoralsurgery.com

PLEASE ANSWER ALL QUESTIONS

PATIENT'S NAME: _____ **DATE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **CELL PHONE:** _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY#: _____ **SEX:** _____ **AGE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

LEGAL GUARDIAN: _____ **PHONE:** _____

ADDRESS: _____ **STATE:** _____ **ZIP:** _____

PATIENT OR PARENT'S EMPLOYER: _____

WORK ADDRESS: _____

NAME OF YOUR ORTHODONTIST: _____

NAME OF YOUR GENERAL DENTIST: _____

NAME OF YOUR FAMILY PHYSICIAN: _____

REFERRED TO THIS OFFICE BY: _____

HAVE YOU, OR A MEMBER OF YOUR FAMILY EVER BEEN A PATIENT? YES___ NO_____ NAME: _____

INSURANCE	**DENTAL**	**MEDICAL**
NAME OF INS. CO.		
NAME OF EMPLOYEE		
EMPLOYED BY		
ID/DOB OF EMPLOYEE		
GROUP NO.		

IS THIS YOUR ONLY INSURANCE POLICY? YES___ NO_____ IF NOT, WHO ELSE DO YOU HAVE INSURANCE THROUGH?

_____

IS THE PATIENT A FULL TIME STUDENT? YES____ NO_____ IF YES, NAME THE SCHOOL THE PATIENT IS ATTENDING.

_____

HOW DO YOU PLAN TO PAY FOR TODAYS VISIT (PLEASE CIRCLE ONE)?

CASH CHECK VISA MASTERCARD DISCOVER AMEX CARE CREDIT

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT DIRECTLY TO FLORIDA ORAL SURGERY OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT AND THAT THIS AUTHORIZATION IS IRREVOCABLE. SIGNATURE OF PATIENT (OR LEGAL GUARDIAN OF MINOR PATIENT): _____ **DATE** _____

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CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of this consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a RIGHT TO REVOKE this consent at any time by giving us written notice of your revocation.

Please understand that revocation of this consent will not affect any action we took prior the arrival of your written revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form. I understand that by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PATIENT/REPRESENTATIVE SIGNATURE:_____ DATE:_____

OFFICE WITNESS SIGNATURE:_____ DATE:_____

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MY FINANCIAL OBLIGATION

I, the patient, or person responsible for payment, understand that Florida Oral Surgery will, as a courtesy, file for payment with my insurance company for my surgery or settle my payment before any procedure is performed by Dr. Charles N. DeWild. If for any reason the insurance company does not honor their contract and payment is not forthcoming I will then be responsible for the full or remaining balance by 60 days after the date of service. If for any reason I fail to pay on any remaining balance I understand that collection measures will be pursued as needed.

PATIENT/REPRESENTATIVE SIGNATURE:_____ **DATE:**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please be advised: Our Notice of Privacy Practices are laminated and featured in the waiting room for your reading convenience. If you would like a hard copy of the Notice of Privacy Practices, we would be happy to assist you, please see the front desk for additional information.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT. The undersigned acknowledges that I have read the Notice of Privacy Practices for FLORIDA ORAL SURGERY.

If you are a legal representative of the patient, please print the patient's name and describe your legal authority for the patient.

Patient's Name:_____ Legal Representative's Name: _____

Relationship to Patient:_____

I have read and know my rights according to the Notice of Privacy Practices for FLORIDA ORAL SURGERY. I understand that a copy of this signed, dated acknowledgement shall be as effective as the original.

PATIENT/REPRESENTATIVE SIGNATURE:_____ **DATE:**_____

OFFICE WITNESS SIGNATURE:_____ **DATE:**_____

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HEALTH HISTORY INFROMATION

NAME_____ DATE:_____

PLEASE CHECK THE BOXES THAT APPLY TO YOUR PAST AND CURRENT HEALTH CONDITIONS:

MEDICAL HISTORY
- ❑ ARTHRITIS
- ❑ PAINFUL/SWOLLEN JOINTS
- ❑ EYE PROBLEMS (GLAUCOMA)
- ❑ STOMACH ULCERS
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ VOMITING OR ACID REFLUX
- ❑ KIDNEY/ BLADDER TROUBLE
- ❑ HEAD OR NECK INJURY
- ❑ BACK/NECK PAIN
- ❑ SHORTNESS OF BREATH
- ❑ HEADACHE/ MIGRAINES
- ❑ SWOLLEN ANKLES
- ❑ PNEUMONIA
- ❑ CHRONIC COUGH
- ❑ FRACTURE OR DISLOCATION
- ❑ NUMBNESS OR TINGLING ANYWHERE
- ❑ THYROID PROBLEMS
- ❑ WEIGHT CHANGE OVER 20 LBS IN PAST YEAR
- ❑ ASTHMA, DATE OF LAST ATTACK_____

DISEASES/DISORDERS
- ❑ EXPOSED TO TUBERCULOSIS
- ❑ AIDS/HIV
- ❑ SKIN DISEASE
- ❑ DIABETES
- ❑ ANEMIA
- ❑ HEPATITIS / JAUNDICE
- ❑ LIVER DISEASE
- ❑ DEFECTIVE IMMUNE SYSTEM
- ❑ EPILEPSY/SEIZURES
- ❑ NEUROLOGIC DISORDER
- ❑ BRONCHITIS/ EMPHYSEMA
- ❑ HORMONE REPLACEMENT
- ❑ OSTEOPOROSIS/THINNING BONES
- ❑ SEXUALLY TRANSMITTED DISEASE
- ❑ SLEEP APNEA/SNORING

CANCER
- ❑ CHEMOTHERAPY
- ❑ RADIATION THERAPY
- ❑ LEUKEMIA
- ❑ CANCER OR TUMOR

ALLERGIES
- ❑ FOOD
- ❑ LATEX
- ❑ METALS
- ❑ SEASONAL ALLERGIES
- ❑ LOCAL ANESTHETIC
- ❑ LIDOCAINE
- ❑ MEDICATIONS:
- ❑ _____

HEALTH CONCERNS
- ❑ SMOKING
- ❑ RECREATIONAL DRUGS OR SUBSTANCES
- ❑ RECOVERING SUBSTANCE ABUSER
- ❑ LUNG INFECTION
- ❑ VASCULAR SHUNT (FOR HEMODIALYSIS OR DRUG THERAPY)

HEART
- ❑ HEART DISEASE
- ❑ HEART INFECTION
- ❑ HEART MURMUR
- ❑ HEART TRANSLPLANT
- ❑ HEART DEFECT
- ❑ HEART ATTACK
- ❑ ANGINA/CHEST PAIN
- ❑ PROSTHETIC HEART VALVE
- ❑ REPAIRED HEART DEFECT
- ❑ HIGH BLOOD PRESSURE
- ❑ LOW BLOOD PRESSURE
- ❑ PACEMAKER/ DEFIBRILLATOR
- ❑ VASCULAR OR CARDIAC REPAIR

BLOOD
- ❑ BRUISE OR BLEED EASILY
- ❑ BLEEDING PROBLEMS
- ❑ STROKE

MENTAL
- ❑ DEPRESSED/BIPOLAR
- ❑ CHANGE IN MEMORY
- ❑ NERVOUS BREAKDOWN
- ❑ PANIC ATTACK
- ❑ PSYCHIATRIC CARE OR COUNSELING
- ❑ A.D.D / A.D.H.D

SURGERIES
- ❑ IMPLANTS
- ❑ PROSTHETIC JOINTS
- ❑ ORGAN OR BONE MARROW TRANSPLANT
- ❑ OTHER_____

ORAL
- ❑ I HAVE HAD LOCAL ANESTHESIA
- ❑ I HAVE HAD GENERAL ANESTHESIA
- ❑ HURTS TO CHEW
- ❑ JAW MAKES CLICKING SOUND
- ❑ EAR ACHES

PREGNANCY
- ❑ NURSING

IS IT POSSIBLE YOU ARE PREGNANT?
- ❑ YES
- ❑ NO

IF YES, PLEASE INDICATE DUE DATE:

_____

FIRST DAY OF YOUR LAST PERIOD:

_____

MEDICATIONS:
DO YOU TAKE?
- ❑ BLOOD THINNERS
- ❑ MEDICINE FOR
- ❑ OSTEOPOROSIS
- ❑ TAKE FOSAMAX OR ACTONEL
- ❑ BIRTH CONTROL
- ❑ BLOOD PRESSURE MEDICINE
- ❑ CHOLESTROL MEDICINE
- ❑ PLEASE LIST OTHER MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____

(OPTIONAL: RELIGIOUS PREFERENCE)

_____

PATIENT SIGNATURE:

_____