PATIENT INFORMATION

First Name ______ M.I. ______ Last Name ______ Sex ___ Male ___ Female
Date of Birth ______ Age ______ Social Security # ______
Home Tel. # (____) ______ Business Tel. # (____) ______ Cell # (____) ______
Address ______ Apt. # ______ City ______ State ______ Zip ______
Mailing Address ______ City ______ State ______ Zip ______
Employer ______ Tel. # (____) ______
Dentist ______ Physician ______ Referred By ______

If other than above, who will be responsible for your account? ☐ Spouse ☐ Mom ☐ Dad ☐ Other
Name ______ Social Security # ______ Tel # (____) ______
Address ______ City ______ State ______ Zip ______
Employer ______ Tel. # (____) ______

Signer below also acknowledges that Yakima Oral Surgery or its agents may use all available phone numbers to contact the patient for follow up appointment or to further conduct business.

Signature of Patient or Person filling out this form: Sign Here

PRIMARY INSURANCE INFORMATION

Policy Holder Name ______
Patient Relationship to Policy Holder: ______
___ Self ___ Spouse ___ Child ___ Other
Sex of Policy Holder ___ Male ___ Female Date of Birth: ______
Policy Holder Address ______
City ______ State ______ Zip ______
Employer ______
Tel. # (____) ______ SS # ______

PRIMARY DENTAL INSURANCE COMPANY:

Name of Ins. Co. ______
Address ______
______
Tel. # (____) ______
Does your plan cover: ☐ Dental ☐ Medical ☐ Both
Group # ______ Group Name ______
Local ______

PRIMARY MEDICAL INSURANCE COMPANY:

Name of Ins. Co. ______
Address ______
______
Tel. # (____) ______
Does your plan cover: ☐ Dental ☐ Medical ☐ Both
Group # ______ Group Name ______
Local ______

SECONDARY INSURANCE INFORMATION

Policy Holder Name
Patient Relationship to Policy Holder: ______
___ Self ___ Spouse ___ Child ___ Other
Sex of Policy Holder ___ Male ___ Female Date of Birth: ______
Policy Holder Address ______
City ______ State ______ Zip ______
Employer ______
Tel. # (____) ______ SS # ______

SECONDARY DENTAL INSURANCE COMPANY:

Name of Ins. Co. ______
Address ______
______
Tel. # (____) ______
Does your plan cover: ☐ Dental ☐ Medical ☐ Both
Group # ______ Group Name ______
Local ______

SECONDARY MEDICAL INSURANCE COMPANY:

Name of Ins. Co. ______
Address ______
______
Tel. # (____) ______
Does your plan cover: ☐ Dental ☐ Medical ☐ Both
Group # ______ Group Name ______
Local ______

Payments are due within 30 days of service. In cases where insurance claims are pending, monthly payments on your account are expected. A finance charge of 1% per month (annual percentage rate of 12%) will appear on ALL charges outstanding for more than 60 days. The patient agrees to pay any collection fees, costs and reasonable attorney fees in the event collection is instituted. We are not providers with DSHS. We do not accept Medical Coupons. We are not a Medicare provider.

Guarantor's Signature ______ Date ______

HEALTH HISTORY

Patient Name ______________________ Age ______ Date of Birth ______________ M____ F____

Height ______ ' ______ " Weight ________ lbs. Patient Phone No. ______________

Medical Doctor: ______________ General Dentist: ______________ Referring Doctor: ______________

Name and phone number of the adult who is your ride, caretaker or emergency contact person:

______________________________ CONFIRMED: Y_____ N_____

HAVE YOU OR DO YOU CURRENTLY HAVE:

Yes	No		Yes	No		Yes	No	
____	____	Asthma	____	____	Diabetes	____	____	Alcohol/Drug Use
____	____	Shortness of Breath	____	____	Ulcer	____	____	High/Low Blood Pressure
____	____	Recent Colds	____	____	Arthritis	____	____	Heart Murmur
____	____	Hay Fever	____	____	Glaucoma	____	____	Rheumatic Fever
____	____	Tuberculosis	____	____	Anemia	____	____	Chest Pain, Angina
____	____	AIDS/HIV +	____	____	Epilepsy/Seizures	____	____	Heart Trouble (Attack)
____	____	Liver Disease	____	____	Bleeding Disorders	____	____	Stroke
____	____	Jaundice, Hepatitis	____	____	Radiation / Chemo Therapy	____	____	Strong Gag Reflex
____	____	Kidney Disease/Dialysis	____	____	Malignant Hyperthermia	____	____	Thyroid trouble
						____	____	Sleep apnea

PLEASE ANSWER GIVING A SHORT EXPLANATION WHERE APPROPRIATE:

Yes	No	
____	____	I am under a physician's care at the present for: ______________
____	____	I have been hospitalized in the last 2 years for: ______________
____	____	Do you or have you ever taken a drug for osteoporosis or bone cancer? If yes when started ________ stopped ________.
____	____	I have been put to sleep for the following operation(s): ______________
____	____	Bad reactions you or your relatives have had to anesthesia: ______________
____	____	Have you ever taken cortisone, ACTH, or other steroid?: ______________
____	____	Have you ever smoked? If so, how much? ______________ When did you quit? ______________
____	____	Do you play a wind instrument?
____	____	Do you ever wear contact lenses? If yes, what type?: ______________ Glasses? ______________
____	____	Do you have any artificial joints or heart valve / replacements? If yes, please explain: ______________

MEDICATION

Please list any pills, drugs, or medications you have taken in the past year and what you are taking them for

Name	Dosage	Condition Being Treated
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

ALLERGIES

Please list any medicines you are allergic to; describe the type of reaction

Name	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

WOMEN

Yes____ No____ Is there a possibility of you being pregnant?

Yes____ No____ Are you currently breast feeding?

Yes____ No____ Are you taking birth control pills? *(Note: Prolonged use of Antibiotics (longer than two weeks) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: ______________________________ Date ______________

Health History Update

Date	Changes	Initials