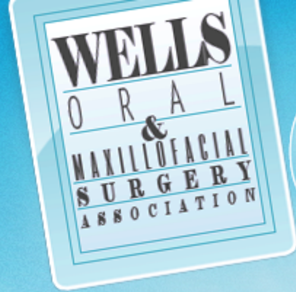

CELEBRATING OVER 30 YEARS OF CARE

WELLS ORAL AND MAXILLOFACIAL SURGERY ASSOCIATION

PATIENT INFORMATION

Date

Last Name | First Name | Middle | Age

Date of Birth | Home Phone | Cell Phone | Email

Current Address | City | State | Zip

If a Student, Name of School | DL# | Social Security Number

Employer | Employer's Address | Work Number

Title/Position | Marital Status | Spouse's name

Employer | Employer's Address | Work Number

Title/Position | Who may we thank for referring you?

FINANCIAL INFORMATION / DENTAL INSURANCE

Insured Name or Guarantor (If, Minor) | Date of Birth | Relationship

Insurance Company | Policy/ID Number | Social Security Number

Union or Group Number | Employer Name and Address

Address for submitting claim ______

MEDICAL INSURANCE

Insured Name or Guarantor (If, Minor) | Date of Birth | Relationship

Insurance Company | Policy/ID Number | Social Security Number

Union or Group Number | Employer Name and Address

Address for submitting claim | Other coverage? | Dental or Medical

Insured Person's Name | Insurance Company | Policy Number

For Insurance Use: Please Sign Appropriately

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of treatment rendered.

Signature of Patient/Guarantor | Date

I hereby authorize payment of group insurance benefits otherwise payable to me, directly to the Wells Oral & Maxillofacial Surgery Association.

Signature of Patient/Guarantor | Date

____
Reason for today's visit

____
Name and address of person responsible for this account

____
Phone

FOR ALL PATIENTS

I hereby authorize Dr. Wells to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the care of the patient above and further authorize and consent that he chooses and employs such assistance as he deems fit. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by Dr. Wells and/or his staff. I agree to pay for all services rendered by this office.

Method of payment for today's visit: Cash MasterCard/Visa Discover American Express Debit Card

Signature of Responsible Party ______ Relationship ______ Date ______

MEDICAL AND DENTAL HISTORY

Answers to the following questions are for our records and are confidential. Please check an answer.

Are you in good health?.......... YES ☐ NO ☐

Are you under the care of a physician or dentist?.......... YES ☐ NO ☐

Physician's name ______ Dentist's Name ______

Have you had any serious illness or operation?.......... YES ☐ NO ☐

If yes, what illness or operation? ______

Have you ever had any unusual reaction to an anesthetic or drugs?.......... YES ☐ NO ☐

If yes, what drugs or medications? ______

Are you taking any medications now?.......... YES ☐ NO ☐

If yes, what? ______

Have you had any radiation treatment for a tumor about your head or neck?.......... YES ☐ NO ☐

Have you taken cortisone or steroids during the past year?.......... YES ☐ NO ☐

Are you pregnant (woman)?.......... YES ☐ NO ☐

Do you currently smoke?.......... YES ☐ NO ☐

If yes, how much?______

Have you used diet pills within the past year?.......... YES ☐ NO ☐

If yes, what? ______

Describe your dental/medical treatment(s) during the past year:

______

Do you have or have you had any of the following?

○ **Rheumatic fever**	○ **Heart trouble**	○ **Mental illness**	○ **Kidney disease**	○ **Stroke**
○ **Hepatitis**	○ **Heart defect**	○ **Drug allergy**	○ **Liver disease**	○ **Diabetes**
○ **Malignancy**	○ **Lung disease**	○ **Drug habit**	○ **Heart Murmur**	○ **Epilepsy**
○ **Scarlet fever**	○ **Sinusitis**	○ **Glaucoma**	○ **Asthma**	○ **Arthritis**
○ **Bleeding tendency**	○ **Sickle cell trait/disease**	○ **High blood pressure**	○ **Venereal disease**	○ **Contact lenses**
○ **Thyroid disease**	○ **TB**	○ **Ulcer**	○ **HIV/AIDS**	○ **Sleep Apnea**
○ **Blood related illness**				

Any disease, condition, or problem not listed above that Dr. Wells should know about?........ YES ☐ NO ☐

If yes, explain ______

I, the undersigned, state that the medical history that I have given is correct to the best of my knowledge.

I have had the opportunity to review the practice's HIPAA (Health Information Portability and Accountability Act) Privacy Statement and understand that I can request a copy of it.

______
Date

Signature ______ Relationship to Patient ______