MANCHESTER ORAL SURGERY

Welcome To Our Practice

Date:	Patient Information			Referring Doctor:
Patient Name	Sex	Age	Date of Birth	Social Security #
Address	Home Phone		Cell Phone	
Parent/Guardian Information				
Father / Guardian Name	Mother Name			
Address	Address			
Home/Cell Phone / Work Phone	Home/Cell Phone		Work Phone	
Employer	Employer			
Social Security # / Date of Birth	Social Security #		Date of Birth	
Primary Insurance Information				
Name of Subscriber	Address			
Home Phone / Work Phone	Employer		Social Security #	Date of Birth
Dental Insurance Name	Phone		ID#	Group#
Medical Insurance Name	Phone		ID#	Group#
Secondary Insurance Information				
Name of Subscriber	Address			
Home Phones / Work Phone	Employer		Social Security #	Date of Birth
Dental Insurance Name	Phone		ID#	Group#
Medical Insurance Name	Phone		ID#	Group#

Please initial all lines and sign below. Thank you.

_____To the best of my knowledge, the above insurance information is complete and accurate. I understand that my insurance is a contract between my employer, the insurance company, and me and that Manchester Oral Surgery is not a party to that contract. I also understand that I am financially responsible for services rendered to me or my child and payment is due at time of service. I will be responsible for a $25 fee for any returned checks and for any legal costs in addition to the unpaid balance for the collection of any past due amounts. I understand that if it is necessary to place my account with a collection agency, in addition to the unpaid balance, I will be responsible to pay an additional 35% of the unpaid balance as a collection fee.

_____I understand that my oral health is part of my overall health. Therefore, I may be referred to another dentist, medical practitioner, or specialist, or I may choose to seek care from another dentist, medical practitioner, or specialist, related to my oral surgery care at Manchester Oral Surgery. I understand that neither Manchester Oral Surgery nor Mark D. Abel, DMD, MD are financially responsible for fees, bills, or liens resulting from care provided by any other health care facility, dentist, medical practitioner, or specialist.

_____I authorize release of any medical or other information necessary to process a claim. I authorize payment of benefits for services rendered to either Mark D. Abel, DMD, MD or to the subscriber according to the policy of this practice.

_____I have been offered a copy of Manchester Oral Surgery's "Notice of Privacy Practices" and have been given the opportunity to ask any questions that I may have regarding this notice.

_____I consent to the disclosure of my protected health information (PHI) to:

_____, with the following restrictions_____

_____.

Name Relationship

(I acknowledge that this consent will remain in place until my written notification requesting a change has been received and processed.)

_____ _____

Signature of Patient/Responsible Party **Date**

HEALTH HISTORY	
Patient Name	Date of Birth

	YES	NO		YES	NO
Are you in good health?			Are you having pain or discomfort at this time?		

Have you had or do you currently have…			Have you had or do you currently have…		
	YES	NO		YES	NO
Rheumatic Fever/Heart Murmur			Hepatitis A/B/C		
Congenital Heart Disease			Liver Disease (Cirrhosis, Jaundice)		
Coronary Artery Disease/Chest Pain			Diabetes		
Stroke (CVA, TIA)			Thyroid Disease		
High Blood Pressure			Arthritis		
Valvular Heart Disease			Ulcers		
Abnormal Heart Rhythm/Pacemaker			Glaucoma		
Heart Failure (ie. CHF)			Osteoporosis		
Lung Disease (Emphysema, TB, Bronchitis)			Implants (Heart valve, hip, knee)		
Asthma			Sinus or Nasal problems		
Seizures/Convulsions/Epilepsy			Cancer		
Bleeding Disorders/Tendencies			Radiation Treatment/Cancer		
Kidney Disease/ Dialysis			TMJ (clicking, popping, pain in front of ear)		
Birth Control Pills			Malignant Hyperthermia		

Other Medical Problems _____
Are you taking any medications of ***any kind*** including aspirin, diet pills or vitamins, if yes please list_____
_____
Allergies to Medications_____Allergy to Latex_____
Have you ever gone to sleep for a surgery?_____
Describe any complications_____
Do you smoke or use smokeless tobacco, if yes how much?_____
History of alcohol and/or drug problems?_____
Do you wear contact lenses?_____
Have you undergone eye surgery in the past eight weeks?_____
Have you ever or are you now receiving Bisphosphonate drug therapy (Aredia, Fosomax, Zometa, Actonel)?___
Is there a chance you might be pregnant?_____
Do you want to talk privately with the doctor about anything?_____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH STATUS, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR ACCORDINGLY.

_____ _____
Patient/Legal Guardian signature (if minor, relationship to patient) Date

FOR OFFICE USE ONLY

DATE_____ BP_____ PULSE_____ HEIGHT_____ WEIGHT_____ PAIN SCORE_____

Reviewed by:_____ Dr._____

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