Midtown Oral & Maxillofacial Surgery

H. Paul Casmedes, D.D.S., M.D.
Board Certified, American Board of Oral & Maxillofacial Surgery

901 West 38th Street, Suite 410
Austin, TX 78705

❑NEW PATIENT ❑ESTABLISHED PATIENT

Pediatrician / Primary Care Doctor:	Referring Physician:

PATIENT INFORMATION

Date: _____

Patient's Last Name:	First:	Middle:	Age:	❑ Male ❑ Female	Date of Birth: / /
Street Address:		Social Security No.:			Primary Phone Number: ( )
City:	State:	ZIP Code:			Secondary Phone Number: ( )

Ethnicity:
- ❑ Hispanic or Latin
- ❑ Not Hispanic or Latin
- ❑ Refuse to Report

Race:
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Native Hawaiian
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Other Race
- ❑ Other Pacific Islander

Primary Parent / Guardian Name:	Email:
	Social Security No.:
Daytime Phone: ( )	Date of Birth:
Employer:	Employer phone No.: ( )
Second Parent / Guardian Name:	Marital Status of Parents: ❑ Married ❑ Divorced ❑ Single
In case of emergency, please contact:	Phone Number: ( ) / Relation:

INSURANCE INFORMATION

❑ Medical ❑ Dental

Name of Primary Insurance:	Subscriber's Name:	Subscribers S.S. #:	Subscribers Date of Birth: / /	❑ Male ❑ Female
Policy No.:	Group No.:	Group Name:		
Subscriber Address: *If different than above*		Patient's relationship to subscriber: Self ❑ Spouse ❑ Child ❑ Other		
City:	State:	ZIP Code:		

❑ Medical ❑ Dental

Name of Secondary Insurance:	Subscriber's Name:	Subscriber's S.S. #:	Subscribers Date of Birth: / /	❑ Male ❑ Female
Policy No.:	Group No.:	Group Name:		
Subscriber Address: *If different than above*		Patient's relationship to subscriber: Self ❑ Spouse ❑ Child ❑ Other		
City:	State:	ZIP Code:		

HEALTH HISTORY

PATIENT NAME: _____ **Date:** _____
Last, **First**

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Are you under the care of a physician? ❑Yes ❑No Date of last visit? _____

Has anyone in your family ever been seen by Dr. Casmedes? ❑Yes ❑No If so, who? _____

Are you in good health? ❑Yes ❑No Height: _____ **Weight:** _____

Have you had any illness, operation or been hospitalized in the past five year? ❑Yes ❑No

If yes, please describe: _____

What are your concerns regarding today's office visit? _____

_____

Have you had or do you currently have…	*Yes*	*No*	*Notes*	*Have you had or do you currently have…*	*Yes*	*No*	*Notes*
Rheumatic Fever?				Kidney trouble?			
Damaged heart valves?				Diabetes?			
Mitral valve prolapses?				Are you on dialysis?			
Heart murmur?				Thyroid problems?			
Heart valve replacement?				Arthritis or joint disease?			
High or low blood pressure?				Prosthetic joint replacement?			
Chest pain (angina)?				Osteoporosis/osteopenia?			
Heart attack(s)?				Osteonecrosis of any bones?			
Irregular heart beat?				History of immunosuppression?			
Pacemaker?				Problems with your immune system?			
Heart Surgery?				Sexually transmitted diseases?			
Swelling of feet or ankles?				AIDS or HIV infection?			
Bronchitis?				History of cancer?			
Asthma?				Chemotherapy or radiation?			
Tuberculosis?				Chronic fatigue or night sweats?			
Emphysema?				Drug or alcohol abuse?			
Other lung trouble?				Eating disorder?			
Blood disorder (anemia)?				Eye disease/glaucoma?			
Blood transfusion?				Do you wear contacts?			
Bruise easily?				Mental health problems?			
Abnormal bleeding?				Pain or clicking of the jaws when eating?			
Hepatitis or other liver disease?				A removable dental appliance?			
Fainting spells?				Do you smoke? (If yes, how many packs per day)?			
Epilepsy or seizures?				Do you consume alcohol? (If yes, how much and how often)?			
Stroke?							
High Cholesterol?							

MEDICATIONS & ALLERGIES

PATIENT NAME: _____
Last, **First**

Is the patient taking or has ever taken:

Y N
- ❑ ❑ Blood thinners (Coumadin, Aspirin, Advil)
- ❑ ❑ History of eating disorder?
- ❑ ❑ Diet pills
- ❑ ❑ Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)
- ❑ ❑ Pain killers (including aspirin)
- ❑ ❑ Tranquilizers
- ❑ ❑ Muscle relaxers
- ❑ ❑ Insulin
- ❑ ❑ Stimulants
- ❑ ❑ Antidepressants

Medication List:

Medication	Dosage	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

Is the patient allergic to, or had a reaction to:

Y N
- ❑ ❑ Penicillin
- ❑ ❑ Sulfa drugs
- ❑ ❑ Other antibiotics
- ❑ ❑ Valium or other tranquilizers
- ❑ ❑ Codeine or other narcotics
- ❑ ❑ Local anesthetic (numbing medicine)
- ❑ ❑ Aspirin/Motrin/Ibuprofen/Tylenol
- ❑ ❑ Latex
- ❑ ❑ Soy or any egg products?
- ❑ ❑ I have no known allergies

Please list any other medications the patient is allergic to:

_____

_____

I **certify** that I have read and I 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/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ **Reviewed by:** _____ **Date:** _____
(parent or guardian if minor)

Print Name:_____

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

Signature of patient: _____ **Reviewed by:** _____ **Date:** _____
(parent or guardian if minor)

AUTHORIZATION

I authorize my surgeon and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of patient: _____ **Reviewed by:** _____ **Date:** _____
(parent or guardian if minor)