

# Columbus Oral and Maxillofacial Surgery, P.C.

(Please complete in full – ink pen only)

www.ColumbusOMS.com

**PATIENT's Legal Name** \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) Nickname \_\_\_\_\_  
Address \_\_\_\_\_ (no. & street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)  
Marital status:  Single  Married  Widowed  Divorced  Separated  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ SSN \_\_\_\_\_  
If Student:  Full-time  Part-time School \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

## PHYSICIANS (Full names please)

Referred by: \_\_\_\_\_ Phone # \_\_\_\_\_  
General Dentist \_\_\_\_\_ Phone # \_\_\_\_\_  
Orthodontist \_\_\_\_\_ Phone # \_\_\_\_\_  
Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

SPOUSE  PARENT or  GUARDIAN Name \_\_\_\_\_  
Address (if different) \_\_\_\_\_ (no. & street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)  
Birth date \_\_\_\_\_ Marital Status \_\_\_\_\_ SSN \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**  Self  Spouse  Parent  Other (specify) \_\_\_\_\_  
Name (if not already given) \_\_\_\_\_ Birth date \_\_\_\_\_ SSN \_\_\_\_\_  
Address (if different) \_\_\_\_\_ (no. & street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

## EMERGENCY CONTACT – Contact friend/relative (NOT LIVING WITH YOU)

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

## DENTAL INSURANCE (IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
SSN \_\_\_\_\_ Policy/Certificate # \_\_\_\_\_  
Employer's Group Name \_\_\_\_\_ Group # \_\_\_\_\_  
Do you have secondary dental/medical? If so, please inform.

## MEDICAL INSURANCE (IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
SSN \_\_\_\_\_ Policy/Certificate # \_\_\_\_\_  
Employer's Group Name \_\_\_\_\_ Group # \_\_\_\_\_

## AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during, and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **Columbus Oral & Maxillofacial Surgery** to release any information (via mail or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to **Columbus Oral & Maxillofacial Surgery** insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Guardian (if minor)

\_\_\_\_\_  
Date

**MEDICAL AND DENTAL HISTORY**

Patient's Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Patient's Current Dentist \_\_\_\_\_ Date of last appt: \_\_\_\_\_

Patient's Current Physician \_\_\_\_\_ Date of last appt: \_\_\_\_\_

Referred to our office by  Self  Friend  Dentist  Physician  Yellow Pages

All past medical and dental history may be important for your optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. Additional space has been allowed on the bottom of this form for your use in fully explaining complex medical problems or concerns. Thank you!

Please list your reason(s) for this visit \_\_\_\_\_

Describe anything that bothers you about the appearance of your teeth, smile, or face \_\_\_\_\_

Describe any injuries or blows to face, jaw, mouth, or teeth \_\_\_\_\_

LIST CURRENT MEDICATIONS (including non-prescriptions/alternative/herbal) \_\_\_\_\_

LIST ALL DRUG ALLERGIES (including past and present) \_\_\_\_\_

LIST ALL PREVIOUS SURGERIES OR HOSPITALIZATIONS \_\_\_\_\_

*Please check all conditions below that apply with a checkmark to indicate YES*

**MEDICAL**

- High Blood Pressure.....
- Chest pains or heart attack.....
- Stroke.....
- Rheumatic Fever.....
- Shortness of breath or swollen ankles.....
- Heart trouble, murmur, mitral valve prolapse.....
- Prosthetic devices (heart, valve, hip, etc).....
- Lung diseases (TB, emphysema, etc).....
- Asthma.....
- Allergies or hay fever.....
- Sinus problems.....
- Mouth breathing or excessive snoring.....
- Ulcers or stomach problems.....
- Diabetes.....
- Hepatitis or liver disease.....
- Kidney or bladder disease.....
- Thyroid problems.....
- Connective tissue disease.....
- Arthritis or rheumatism.....
- Cancer (type & year).....
- Serious illness not listed (list below).....
- Subject to prolonged bleeding or bruise easily.....
- Wear contact lenses.....
- Glaucoma.....
- Epilepsy, convulsions, or seizure history.....
- Psychiatric therapy or emotional problems.....
- Sexually transmitted disease.....
- Pregnant or possibly pregnant?.....
- Taking birth control pills.....

- Drink coffee ( \_\_\_\_\_ cups per day).....
- Use of tobacco (types & how much?).....
- Consume alcoholic beverages?.....
- Pain, popping, catching, locking in jaw joints.....
- Clench or grind your teeth?.....
- Wake up with sore jaws?.....
- Frequent headaches (How many per week? \_\_\_\_\_ ).....
- Dizziness, ringing, pain in ears?.....
- Tenderness or stiffness in the jaw, neck, or back?.....
- History of TMJ (jaw joint) problems.....
- Taking diet pills (prescription or non-prescription.....

**DENTAL**

- Treated for or diagnosed with gum disease.....
- Treated for or consulted for orthodontic therapy.....
- Previous oral surgery.....
- Dental x-rays in the last year?.....
- Excessive fear of dental treatment.....
- Brush your teeth (how often?).....
- Floss your teeth (how often?).....
- Bad breath or unpleasant taste in mouth.....
- Bleeding gums/Sore teeth.....
- Gags easily.....
- Tooth sensitivity.....
- Fever blisters or mouth ulcers.....
- Suck your thumb, finger, lip (now or in the past?).....
- Tongue thrusting habit.....
- Place a high priority on keeping natural teeth.....

*Please use this space to expand on the above information or add anything else you feel is important:*

The above information is accurate and complete to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

IF MINOR – Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Dr's initials \_\_\_\_\_

Date UPDATED \_\_\_\_\_ Patient initials \_\_\_\_\_ Dr's initials \_\_\_\_\_