# Monteleone & Kessler, P.L.

Kevin L. Monteleone, D.D.S., P.A.
Michael W. Kessler, D.D.S., P.L.

American Board of Oral and Maxillofacial Surgery

American Association of Oral and Maxillofacial Surgeons

## PATIENT INFORMATION (CONFIDENTIAL)

Date_____

Patient name _____ Nickname_____ S.S. #_____ Date of Birth _____Age_____

Address_____Apt_____City_____ State_____ Zip_____

How Long_____ Driver's License# _____ Height_____ Weight_____

Home Phone #_____Business Phone #_____Cell/Pager_____

Best time of day to contact you: _____

Check one: Minor _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed_____

If student, name of school/college_____City_____State____ Full or Part Time

Employer_____Work #_____Ext_____

Business Address_____City_____State____ Zip_____

E-Mail Address_____

Whom may we thank for referring you to our office? _____ Patient _____Friend _____Doctor _____Other

Name of Referral Source_____

Person to Contact In Case of Emergency_____Phone_____

Do you approve our office to take photos of you for chart records? Please circle: Yes or No

## RESPONSIBLE PARTY

Person responsible for account_____Relationship to patient_____

S.S. #_____ Date of Birth_____ Driver's License# _____

Address_____Apt_____ City_____ State_____ Zip_____

Home Phone #_____Business Phone #_____Cell/Pager_____

## INSURANCE INFORMATION

Address_____Apt_____ City_____ State_____ Zip_____

Phone #_____

Employer_____Work #_____Ext_____

Dental Insurance Company _____Group #_____Phone #_____

Insured Name _____ Insurance ID # _____

We offer the following methods of payment. **Payment is expected in full at each appointment.** Cash Check Visa MasterCard Discover Amex

**Purpose of this Visit:**

_____

_____

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**Please answer the following. It is important you fill in every space, including addresses and phone numbers. Your answers are for your records only and will remain confidential.**

## PATIENT MEDICAL HISTORY

Yes No Are you under the care of a Physician? If so, what is the condition being treated? _____
Physician Name _____
Address_____Phone # _____
Yes No Are you under the care of a Dentist? Date of last visit _____
Dentist Name _____
Address_____Phone # _____
Yes No Have you serious illness? When? _____
Please be specific_____
Yes No Have you been hospitalized, had a serious illness, or had surgery? If so, when? _____
Anesthesia administered? _____ Were there any complications from the surgery or anesthesia? _____
Surgery and name of operating surgeon _____

Social History:

Yes No Do You Smoke? _____ Packs per day Yes No Do You Drink? _____Drinks per day

**Do you have or have had any of the following illnesses or disorders? Please use the right side of this form if you need more room, and please be specific. These questions are important to your health.**

Yes / No Rheumatic fever or rheumatic heart disease
Yes / No Congenital heart lesions or heart murmur
Yes / No Cardiovascular disease (heart disease, heart attack) When? _____
Yes / No High blood pressure, arteriosclerosis or stroke
Yes / No Pain in your chest upon exertion
Yes / No Emphysema/shortness of breath/respiratory problems
Yes / No Pacemaker/artificial heart valves/artificial joints……Procedure Date _____
Yes / No Diabetes
Yes / No Sinus trouble
Yes / No Asthma or hay fever
Yes / No Hives or skin rash
Yes / No Fainting spells, dizziness, or seizures
Yes / No Kidney disease
Yes / No Frequent Urination
Yes / No Frequent thirst/dry mouth
Yes / No Cancer/chemotherapy/radiation….When? _____
Yes / No Thyroid problems
Yes / No Arthritis
Yes / No Inflammatory rheumatism (painful swollen joints)
Yes / No Stomach ulcers
Yes / No Kidney trouble
Yes / No Tuberculosis
Yes / No Persistent cough or coughing up blood
Yes / No Low blood Pressure
Yes / No Bruise easily
Yes / No Abnormal bleeding with any previous dental work
Yes / No Blood disorder (such as anemia), if so list type: _____
Yes / No Blood transfusion, if so explain_____
Yes / No Surgery or x-ray treatment for tumor, growth or other condition of head or
Neck (Please explain) _____
Yes / No Hepatitis, jaundice or liver disease, if so explain type: _____
Yes / No Sexually Transmitted Disease, if so list type: _____
Yes / No HIV positive /AIDS / 0ther_____

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**Are you taking any of the following? If so, please list the NAME, DOSAGE and CONDITION being treated.**

Yes / No Antibiotics or sulfa drugs_____ Dosage_____ am/pm
Yes / No Anticoagulants (blood thinners) _____ Dosage_____ am/pm
Yes / No Medicine for high blood pressure_____ Dosage_____ am/pm
Yes / No Cortisone steroids _____ Dosage_____ am/pm
Yes / No Tranquilizers_____Dosage_____ am/pm
Yes / No Antihistamines_____ Dosage_____ am/pm
Yes / No Aspirin_____ Dosage_____ am/pm
Yes / No Insulin, Tolbutamide or similar drug_____ Dosage_____ am/pm
Yes / No Digitals or drugs for heart trouble_____ Dosage_____ am/pm
Yes / No Nitroglycerin_____ Dosage_____ am/pm
Yes / No Other drugs or medications_____Dosage_____ am/pm

Yes / No Have you received or are you currently receiving medication know as bisphosphonates (For example, zoledronic acid (Zometa), alendronate (Fosamax), risronate (Actonel), bandronate (Boniva), clodronate (Bonefos) or pamidronate (Aredia))?

* If Yes, Have you noticed any changes in your mouth or jaw? Yes_____ No_____
Have you had any jaw pain or toothache? Yes_____ No_____
Have you noticed any foul smell, swelling or discharge in your mouth? Yes_____ No_____

**Are you ALLERGIC OR HAVE YOU REACTED ADVERSELY to any of the following? If so, Please explain.**

Yes / No Local anesthetics (e.g. Novocain) _____
Yes / No Aspirin_____
Yes / No Barbiturates, sedatives or sleeping pills _____
Yes / No Codeine or other narcotics_____
Yes / No Iodine _____
Yes / No Penicillin or other antibiotic _____
Yes / No Sulfa drugs_____
Yes / No Other_____
Yes / No Are you wearing contact lenses?
Yes / No Have you had any serious trouble associated with any previous dental treatment?
If so, explain: _____

Yes / No Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?

## Women

Yes / No Pregnant? Or Possibly pregnant?
Yes / No Do you have problems associated with menstruation?
Yes / No Hormonal Replacement Therapy Medication _____
Yes / No Birth Control Pills Type/Dosage _____

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Signature of Patient or Legal Guardian Date

**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 depending upon special circumstances. An estimate of the charges 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 assist you with filling out the proper forms, but please complete the identifying information at the top of the 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 charges. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your Insurance Company. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me.