COASTAL AND MAXILLOFACIAL SURGERY, P.C.

9221 UNIVERSITY BLVD., BUILDING D, SUITE 1-A
NORTH CHARLESTON, SC 29406

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS		APT #
ZIP CODE	CITY	STATE
PHONE #	SOCIAL SECURITY #	BIRTHDAY
SEX M/F	MARITAL STATUS ☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED	
STUDENT ☐ FULL ☐ PART ☐ NONE	EMAIL ADDRESS	

SPOUSE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
PHONE #	SOCIAL SECURITY #	BIRTHDAY

PARENT INFORMATION

MOTHER'S NAME		BIRTHDAY
PHONE #	SOCIAL SECURITY #	
FATHER'S NAME		BIRTHDAY
PHONE #	SOCIAL SECURITY #	

INSURANCE INFORMATION

Please give any insurance cards to the front desk assistant for scanning.
If you have given the card to scan, you may disregard filling in the ID #,
Group #, Address, and Phone # of the Insurance Company.

INSURANCE COMPANY	☐ PRIMARY ☐ SECONDARY
POLICY #/ ID #	GROUP #
INSURANCE ADDRESS:	PHONE #
INSURED'S NAME	RELATIONSHIP TO PATIENT:
INSURED'S DOB:	INSURED'S SOCIAL SECURITY #
INSURED'S EMPLOYER	EMPLOYER #

If the patient is covered by <u>another</u> insurance policy, please fill in the second section on the back side of page for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE COMPANY		☐ PRIMARY ☐ SECONDARY
POLICY #/ ID #		GROUP #
INSURANCE ADDRESS:		PHONE #
INSURED'S NAME	RELATIONSHIP TO PATIENT:	
INSURED'S DOB:	INSURED'S SOCIAL SECURITY #	
INSURED'S EMPLOYER		EMPLOYER #

COASTAL ORAL AND MAXILLOFACIAL SURGERY, P.C.

JEFFREY S. HALL, M.D., D.M.D.

AAOMS National Insurance Company
Risk Retention Group, Exclusive to the OMS

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

_____

_____

10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Coastal Oral and Maxillofacial Surgery Financial Policy

Our office will contact your insurance company to verify insurance and an estimate percentage of coverage. The estimated co-pay is due at the time of surgery. If the insurance pays less than the quoted estimate, the patient is responsible for the payment of the balance.

_____ _____

Signature of Patient or Legal Guardian Date

Authorization to Release Health Care Information

I request and authorize _____ and practice to release health care information of

the patient, _____, to:

Name: Jeffrey S. Hall, MD, DMD

9221 University Boulevard

Building D, Suite 1-A

Charleston, SC 29406

Office: (843) 569-0904 Fax: (843) 569-0961

Email: xrays@comsurgery.com

THIS AUTHORIZATION EXPIRES ON _____ or 365 DAYS AFTER THE DATE IT IS SIGNED.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

• Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

• Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____ _____

Signature of Patient or Patient's Authorized Representative/ Legal Guardian Date signed