PERMIAN BASIN
ORAL SURGERY & DENTAL IMPLANT CENTER

Patient#: ________________

Date: ________________

☐ Midland Office
☐ Odessa Office

General Patient Information

Patient Full Name: ____

Date of Birth: __________ Age: ______ Sex: ☐ Male ☐ Female Height: _______ Weight: _______

Social Security #: ______________________ Drivers License #: ______________________

Address: ____ Apt #: __________

City: ______________ State: ________ Zip: _________ Email: ____________________

Primary Phone #: ____________________ ☐ Self ☐ Other: ____________ Text? ☐ Yes ☐ No

Secondary Phone #: ____________________ ☐ Self ☐ Other: ____________ Text? ☐ Yes ☐ No

Employer: ______________________________

☐ Married ☐ Single ☐ Divorced ☐ Widowed Name of Spouse: ____________________

Emergency Contact: ______________________________________ Ph#: ______________

General Dentist: ______________________ Referring Dentist/Doctor: ______________________

RESPONSIBLE PARTY (FINANCIAL):

If the patient is under 20, the person accompanying him/her is responsible for the account.
Please fill in the following information for the person who is in the office with the minor patient.

Parent/Guardian Name: __________________________ Relationship to Patient: ______________

Date of Birth: ______________ Soc. Sec. #: __________________

Address: ________________________ City: ______________ State: _______ Zip: ________

Ph#: ______________________________ Work Ph#: ______________________________

Employer: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, ______________________________________ have received a copy of
(NAME OF PATIENT)

Permian Basin Oral Surgery & Dental Implant Center's Notice of Privacy Practices.

Signature: ____ Date: ________________
(PARENT OR GUARDIAN IF MINOR)

FOR OFFICE USE ONLY

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

__________ Patient refused to sign
__________ Emergency situation kept us from obtaining patient's signature
__________ Language barriers kept us from obtaining patient's signature
__________ Other: ______________________________________

PERMIAN BASIN
ORAL SURGERY & DENTAL IMPLANT CENTER

Patient#: ______________________
Name:_________________________

Medical History

***Please answer all questions correctly and completely. Your answers are for our records only and will be kept confidential.**

Do you have, or have you had, any of the following diseases or problems?:

Yes No

Rheumatic Fever or Rheumatic Heart Disease

Heart Defects Present from Birth

Heart Disease, Heart Attack, Angina, Coronary Artery Problems, Heart Murmur, Stent Placement, Abnormal Rhythm

Chest Pain upon Exertion

Difficulty Walking up One Flight of Stairs Without Resting

Ankle Swelling

Shortness of Breath while Lying Flat or Require Extra Pillows when Sleeping

High Blood Pressure (Hypertension)

Low Blood Pressure (Hypotension)

History of Stroke

Fainting Spells or Seizures

Lung Disorders such as Asthma, COPD, Bronchitis,
Other: __________________________________
If Asthma:
Last ER Visit __________
Hospital Admission __________
Most Recent Episode __________
Sleep Apnea (CPAP Setting:_______________)

Tuberculosis

Persistent Cough or Coughing up Blood

Yes No

High Thyroid (Hyperthyroid)

Low Thyroid (Hypothyroid)

Stomach Ulcers, GERD (Acid Reflux) or Other Intestinal Disorders

Hepatitis (A,B,C); Cirrhosis, Fatty Liver or Other Liver Diseases

Kidney Trouble, Kidney Failure, Dialysis

Inflammatory Rheumatism, Arthritis

Immune System Disorder

Blood Disorders (Anemia, Leukemia, etc.)

Clotting Disorder or Abnormal Bleeding Associated with Previous Surgery, Trauma or Extractions

Transfusion of Blood or Blood Products

Had Surgery, Radiation or Chemotherapy for Tumor Growth or Cancer (Please Clarify: ___________
____

Any Prosthetic (Artificial) Joints:
List Surgery and Date:____________________
____

Emotional or Psychiatric Disorders

Glaucoma

Seasonal Allergies or Sinus Trouble

Osteoporosis

Diabetes (Average Morning Blood Sugar Level: __________) (Last Hemoglobin A1C: _____)

Yes No

Has there been any change in your health in the past year?

Have you had any serious illness, operation or hospitalization in the last 5 years?

If yes, please explain: ____

Date of last physical exam: __________________________

Are you now under the care of a physician?

Condition being treated?____

Physician's name: ____

Physician's address: ____

Have you had any serious problems associated with any previous dental treatment?

If yes, please explain: ____

Do you currently or have ever had any TMJ or jaw joint problems?

Do you smoke? If yes, packs per day _______for ___________ years

Do you or have you ever used marijuana, methamphetamines, cocaine, crack, or heroin?

If yes, please clarify:____

Do you drink alcoholic beverages? If yes, how much and how often?: ________________

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Patient#: ____________________
Name: ______________________

Medical History (Cont.)

***Please answer all questions correctly and completely. Your answers are for our records only and will be kept confidential.**

WOMEN ONLY

Birth Control Or Hormones
Problems Related to Menstrual Cycle?
Pregnant- Trimester ________
Nursing

MEN ONLY

Do you have any prostate gland problems?

ALLERGIES

Are you allergic to or have you had a reaction to ANY of the following;

Local Anesthetics (Numbing Medication)
Barbiturates, Sedatives, Sleeping Pills
Narcotics (Demerol, Fentanyl, Codeine, Hydrocodone)
Penicillin/Amoxicillin
Latex
Valium/Versed
Asprin, Ibuprofen (Advil, Motrin)
Iodine
Other Antibiotics (If So, List:____)
Others Allergies:____

MEDICATIONS

Please list all prescription medications, non-prescription, hormones, vitamins and “Alternative” or “Natural” Medications:

____

____

____

Select The Following Drugs You Have Used At Any Time To Treat Osteoporosis or Cancer

Fosamax	Zometa
Didronel	Skelid
Aredia	Actonel
Boniva	Reclast
Xgeva	Bisphosphonate

Select The Following Drugs You Have Used At Any Time To Treat Autoimmune Diseases

Humira	Enbrel
Cosentyx	Orencia
Rituxan	Tysabri
Stelara	Taltz
Prednisone	Other:__________

Any condition/disease not listed above that Doctor should know about?

If so, please explain:____

____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Permian Basin Oral Surgery of any changes.

Patient Signature: ______________________________________ Date:______________
(PARENT OR GUARDIAN IF MINOR)

FOR OFFICE USE ONLY

Date ____________	Date ____________	Date ____________
BP ____________	BP ____________	BP ____________
Pulse ____________	Pulse ____________	Pulse ____________
Resp. ____________	Resp. ____________	Resp. ____________
Temp. ______ EAC ______	Temp. ______ EAC ______	Temp. ______ EAC ______
O2 Sat. ____________	O2 Sat. ____________	O2 Sat. ____________

Patient #: _______________

Name: ______________________________

HIPAA Consent for Patient Information Release

I authorize Permian Basin Oral Surgery & Dental Implant Center to release my personal health information to family members or others involved in my care or assisting me with financial arrangements. ☐ Yes ☐ No

These are the individuals with whom Permian Basin Oral Surgery & Dental Implant Center is allowed to share information:

- Name:____Relationship:________________

  Phone # or Contact Information:____

- Name:____Relationship:________________

  Phone # or Contact Information:____

- Name:____Relationship:________________

  Phone # or Contact Information:____

Privacy Information

Please check **YES** or **NO** for the following statements. By checking YES for the following statements this office will leave voicemail or answering machine messages at your home, work or emergency contact on file that may include protected health information and may be overheard by others not involved in your care.

PLACE	CALLBACK/MESSAGE	DETAILED MESSAGE
Home	☐ Yes ☐ No	☐ Yes ☐ No
Work	☐ Yes ☐ No	☐ Yes ☐ No
Text	☐ Yes ☐ No	☐ Yes ☐ No
Email	☐ Yes ☐ No	☐ Yes ☐ No

Signature: ____ Date: ____________________

(PARENT OR GUARDIAN IF MINOR)

Any changes to this form must be initiated by the patient and submitted on a new form.

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Patient #: _______________

Name: ____________________________

Financial Policy

Thank you for choosing us as your oral surgery provider. We make every effort to keep down the cost of your care. You can help by supplying correct information to us in regard to your insurance policy and person responsible for the account. An estimate of charges for any procedures or surgery you may require will be given to you following the consultation.

Payment in full is expected when services are rendered. Although your insurance may assist you with partial payment of your treatment, the estimated portion that is not covered is due when services are rendered. If insurance pays less than the estimate, you will be billed for the remaining balance. If insurance payment results in a credit, a refund check will be issued.

As a courtesy to our patients, we will file your primary insurance for you. Insurance coverage varies between dental and medical and we will file the claim accordingly. Our office is an out-of network provider with all insurance companies. Charges for services rendered are ultimately your responsibility to pay. We are not a party in your insurance policy and therefore are not liable to write off any fees or charges regardless of insurance benefits/non covered services/usual and customary fees/or any determinations made by your insurance company.

Remember, insurance policies are to assist the patient and are not a substitute for payment. If your insurance has not paid within 60 days from the day of service, any balance will become your responsibility. We will, however, continue to work with your insurance company to ensure they process the claim.

- I understand and agree that I am ultimately responsible for all fees incurred.
- I agree to pay any and all unpaid balances on my account.
- I understand and agree if patient is a minor/student/under the financial responsibility of their parent, the parent accompanying the patient will be responsible for the account and this office will not involve itself in divorce/separation/guardianship/decree situations.
- I understand and agree that it is my responsibility to supply all current and correct primary insurance information.
- I understand and agree if insurance has not paid within 60 days from the day of service, any balance will become my responsibility.
- I authorize all insurance benefits to be paid to Permian Basin Oral Surgery & Dental Implant Center.
- I authorize the release of my information to my insurance company to obtain reimbursement of any claim(s) or records purposes.
- If payment by the insurance is made to the insured, I agree to endorse or have the insured endorse the benefits check or make immediate payment to Permian Basin Oral Surgery & Dental Implant Center.
- I authorize this office to discuss my account with a spouse or parent/step parent (if patient is not a minor but using their insurance).
- I have read, understand and agree to the above terms.

Signature: ____ Date: ____________________

(PARENT OR GUARDIAN IF MINOR)

MEDICAL - PRIMARY

Insurance Company: __________________________

Insured Name: ______________________________

Insured SS#: ________________________________

Insured Date of Birth: ________________________

Insured Employer: ___________________________

DENTAL - PRIMARY

Insurance Company: __________________________

Insured Name: ______________________________

Insured SS#: ________________________________

Insured Date of Birth: ________________________

Insured Employer: ___________________________

YOU WILL RECEIVE A COPY OF THIS FORM AT YOUR REQUEST