Profiles Oral & Facial Surgery
Health History Form

Patient's Name _____ Date of Birth ____/____/____ Age _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Referring Doctor's Name: _____ Reason for Visit _____

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please describe the symptoms you are currently having today: _____

Have there been any changes in your general health in the past year? ☐ Yes ☐ No
If yes, please describe: _____

Are you now under a physician's care for a particular problem at this time? ☐ Yes ☐ No

If yes, why? _____ Date of last physical exam ____/____/____

Have you ever been hospitalized, had a serious illness, or had any surgeries in the last 5 years? ☐ Yes ☐ No
If yes, please explain? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	☐ Yes ☐ No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	☐ Yes ☐ No
		Glaucoma?	☐ Yes ☐ No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	☐ Yes ☐ No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	☐ Yes ☐ No
Kidney disease or kidney failure, requiring dialysis?	☐ Yes ☐ No	Liver disease (jaundice, hepatitis A, B, or C)?	☐ Yes ☐ No
Thyroid disease?	☐ Yes ☐ No	Diabetes?	☐ Yes ☐ No
Stomach ulcers or colitis?	☐ Yes ☐ No	Arthritis?	☐ Yes ☐ No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	☐ Yes ☐ No	Significant weight loss or gain?	☐ Yes ☐ No
		Seizures, convulsions, epilepsy, fainting or dizziness?	☐ Yes ☐ No
Frequent or recurring mouth sores?	☐ Yes ☐ No	Sinus or nasal problems?	☐ Yes ☐ No
Radiation to the head or neck for cancer treatment?	☐ Yes ☐ No	Osteoporosis or osteopenia?	☐ Yes ☐ No

Any disease, chemotherapy or transplant operation? Cancer? ☐ Yes ☐ No
If so, where? _____, and when was the date of your last treatment? _____
If you've answered **YES** to any of the above questions, please explain: _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? ☐ Yes ☐ No
If yes, please explain: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____ **Phone Number:** _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

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MEDICATIONS

Are you using any of the following:

Antibiotics? ☐ Yes ☐ No

Anticoagulants (blood thinners)? ☐ Yes ☐ No

Heart drugs? ☐ Yes ☐ No

Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants ☐ Yes ☐ No

Prescription pain medication? ☐ Yes ☐ No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? ☐ Yes ☐ No

Insulin or oral anti-diabetic drugs? ☐ Yes ☐ No

High blood pressure medications? ☐ Yes ☐ No

Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? ☐ Yes ☐ No
If yes, list drugs used and time of use.
_____
_____

Please list **ALL** medications you are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? ☐ Yes ☐ No

Food products? ☐ Yes ☐ No _____

Sedatives, barbiturates? ☐ Yes ☐ No _____

Codeine or other pain killers? ☐ Yes ☐ No _____

Aspirin, Motrin, Aleve, or ibuprofen? ☐ Yes ☐ No _____

Penicillin or other antibiotics? ☐ Yes ☐ No _____

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? ☐ Yes ☐ No

If yes, which anesthetic? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:

Drug abuse? ☐ Yes ☐ No

Emotional disorders? ☐ Yes ☐ No

Alcoholism? ☐ Yes ☐ No

Do you use:

Alcohol? ☐ Yes ☐ No How often? _____

Marijuana? ☐ Yes ☐ No How often? _____

Recreational drugs? ☐ Yes ☐ No How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? ☐ Yes ☐ No If Yes, please explain? _____

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

PROFILES ORAL & FACIAL SURGERY

PATIENT INFORMATION

Patient's Name:_____ Date: _____

Sex____ Age:_____ Birth Date:_____ Soc. Sec.# _____

Address: _____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ Work #: _____

Email Address: _____

Spouse's Name (if minor, parent's name): _____

Dental Insurance Plan:_____ Member ID #: _____

Primary Subscriber Name:_____ D.O.B. _____

****Medical insurance information is needed as some dental carriers require oral surgery to be submitted to your medical insurance prior to paying your claim.****

Medical Insurance Plan:_____ Member ID #: _____

Insurance Telephone #: _____

Primary Subscriber Name:_____ D.O.B. _____

Responsible Party's Name:_____ D.O.B. _____

Address: _____

City:_____ State:_____ Zip:_____

Family members who have been patients here:_____

Emergency Contact: _____

Relationship:_____ Phone #: _____

We request that charges for services rendered be paid at the conclusion of each visit. We accept the following forms of payment:

• All major credit cards accepted • Cash • Money Order • CareCredit® • LendingClub®

Insurance is filed as a courtesy to our patients. Our office will allow 90 days for the insurance company to respond. If no response is received within the 90 days, you will be responsible for the entire amount due. All costs including collection fees, court costs and reasonable attorney fees will become the financial responsibility of the signing party if payment is not received as described above. Your signature indicates agreement with the above stipulations.

_____

PATIENT/GUARDIAN SIGNATURE **DATE**

oral & facial
surgery center
Dr. Charles & Associates

INSURANCE WAIVER

Thank you for choosing Profiles Oral and Facial Surgery Center to provide for your oral and maxillofacial needs. We will gladly assist in the filing of your insurance claims so that you might receive the full benefit available from your insurance company. For out of network insurances, we can file as a courtesy to you for your reimbursement.

ESTIMATION OF BENEFITS:
We cannot be held responsible for knowing all the peculiarities (ie: specifics in coverage or changes in coverage) of all the insurance companies that we deal with. It is your responsibility as the insured to become familiar with your own policy. If there is a peculiarity about your insurance company of which you do not inform us, and it results in an underpayment of benefits, we will not be held responsible and any balance will fall to the patient's responsibility. Any balance accrued will be due thirty days from the time the claim has processed in our office.

CHANGE OF INSURANCE:
If at any point during treatment, your insurance changes for any reason, it is your responsibility to let the office know of this change. If your insurance changes from a plan that we take initially to a plan that we no longer take, therefore causing your treatment to be considered "non-covered" or "out of network", any balance will fall to the patient's responsibility. Any balance accrued will be due thirty days from the time the claim has processed in our office.

MISCELLANEOUS:
In the case of divorced parents, the parent that brings in the patient and signs the treatment plan will be the responsible party.

I fully understand the conditions of the Insurance Agreement and agree to abide by the limitations set forth. I also understand that I have primary duty to pay Profiles Oral and Facial Surgery Center and am responsible for the entire contract fee if insurance fails to pay. I hereby authorize payment to Profiles Oral and Facial Surgery Center. _____ **(initials)**

We look forward to serving your oral surgery needs and we sincerely hope you decide to move forward with our practice!

Signature: _____ **Date Signed:** _____
(Responsible Party)

PROFILES ORAL & FACIAL SURGERY CENTER

2051 45th Street, Suite 205
West Palm Beach, FL 33407
(561) 622-9065

2560 RCA Blvd., Suite 102
Palm Beach Gardens, FL 33410
(561) 622-9065

24 N Loxahatchee Dr., Suite 1
Jupiter, FL 33458
(561) 622-9065

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date: _____

Relationship to patient (if signed by a representative of patient): _____

Submit