SIGNATURE ORAL SURGERY

New Patient Intake Form

Washington / Romeo
12150 30 Mile Rd., Suite 202, Washington, MI 48095
Phone (586) 752-9691 | Fax (586) 752-6199

New Baltimore / Chesterfield
35050 23 Mile Rd., Suite C, New Baltimore, MI 48047
Phone (586) 725-2400 | Fax (586) 725-2405

Please complete every page and bring this form to your appointment. You can type into this PDF and print it, or print it and fill it in by hand. Prefer to do it online? Visit signature-oms.com/patient-intake-form.

OFFICE LOCATION

Which office will you be visiting?

☐ Washington/Romeo ☐ New Baltimore/Chesterfield

DEMOGRAPHIC INFORMATION

Patient Information

Prefix

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name | M.I. | Last Name

Please do not input special characters into your name, including hyphens.

Maiden Name (if applicable, e.g., previous patient)

Birth Date | Age | Social Security Number

Sex

☐ Male ☐ Female ☐ Decline to say

Mailing Address | Apt.

City | State | ZIP Code

Driver's License Number | Issuing State

E-mail Address

Primary Phone

May we send text messages to this phone?

☐ Yes ☐ No

Secondary Phone

May we send text messages to this phone?

☐ Yes ☐ No

Were you referred to our practice by your dentist?

☐ Yes ☐ No

If no, how did you hear about us?

☐ Medical Doctor ☐ Other Dental Specialist ☐ Family Member ☐ Friend ☐ Social Media ☐ Advertising ☐ Other

If other, please specify

Have you ever been a patient of our practice?

☐ Yes ☐ No

If yes, approximately when?

Dentist First Name

Dentist Last Name

Dentist Office City

Dentist Phone

When were you last there?

Medical Doctor First Name

Medical Doctor Last Name

Medical Doctor Office City

Medical Doctor Phone

When were you last there?

Preferred Pharmacy

Pharmacy Phone

Pharmacy Street

Pharmacy City

Employer / Business Name

Business Phone

Does the patient have a legal guardian?

☐ Yes ☐ No

Guardian First Name

Guardian Last Name

Does the patient require an interpreter?

☐ Yes ☐ No

If yes, what language?

Interpreter

☐ Patient will bring their own interpreter

Emergency Contact

Please Contact

Phone

Relation to Patient

Who will be responsible for your account?

Who will be responsible for your account?

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Legal Guardian ☐ Other

Legal Guardian's Name

Other - please describe

First Name M.I. Last Name

Birth Date Social Security Number

Email

Address Apt.

City State ZIP Code

Responsible Party's Phone

Employer

Is this related to an accident?

Is this visit related to an accident?

☐ Yes ☐ No

If yes, indicate type of accident

☐ Automobile ☐ Work related ☐ Other

If other, please specify

Date of Injury

Insurance company handling this claim Insurance Claim Number

Name of Attorney / Adjustor Attorney / Adjustor Phone

INSURANCE INFORMATION

General Insurance Information

Please select one

☐ Yes, there is insurance. ☐ NO INSURANCE

Student

☐ Full-time ☐ Part-time ☐ Not a student

Marital Status

☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

Employed

☐ Full Time ☐ Part Time ☐ Retired ☐ Not employed

Primary Dental Insurance Information

☐ None - no coverage of this type

Insurance Company Name

Policy I.D. Number

Group Number

Employer / Business

Subscriber

☐ Self ☐ Non-Self (please complete subscriber information)

Subscriber's First Name

Subscriber's Last Name

Relation

Subscriber Birth Date

Subscriber Sex

☐ Male ☐ Female

Subscriber S.S. #

Subscriber Address

☐ Same ☐ Different

Street Address

City

State

ZIP Code

Primary Medical Insurance Information

☐ None - no coverage of this type

Insurance Company Name

Policy I.D. Number

Group Number

Employer / Business

Subscriber

☐ Self ☐ Non-Self (please complete subscriber information)

Subscriber's First Name

Subscriber's Last Name

Relation

Subscriber Birth Date

Subscriber Sex

☐ Male ☐ Female

Subscriber S.S. #

Subscriber Address

☐ Same ☐ Different

Street Address

City State ZIP Code

Do you have secondary dental or medical insurance?

☐ Yes ☐ No

Secondary Dental Insurance Information

☐ None - no coverage of this type

Insurance Company Name

Policy I.D. Number Group Number

Employer / Business

Subscriber

☐ Self ☐ Non-Self (please complete subscriber information)

Subscriber's First Name Subscriber's Last Name

Relation Subscriber Birth Date

Subscriber Sex

☐ Male ☐ Female

Subscriber S.S. #

Subscriber Address

☐ Same ☐ Different

Street Address

City State ZIP Code

Secondary Medical Insurance Information

☐ None - no coverage of this type

Insurance Company Name

Policy I.D. Number Group Number

Employer / Business

Subscriber

☐ Self ☐ Non-Self (please complete subscriber information)

Subscriber's First Name Subscriber's Last Name

Relation

Subscriber Birth Date

Subscriber Sex

☐ Male ☐ Female

Subscriber S.S. #

Subscriber Address

☐ Same ☐ Different

Street Address

City

State

ZIP Code

HEALTH HISTORY

Patient Legal First Name

M.I.

Patient Legal Last Name

Person Filling Out

☐ Self / Patient ☐ Guardian / Other ☐ Medical Power of Attorney

If not patient, relationship

HEALTH HISTORY QUESTIONNAIRE

Health problems that you may have or medications that you may be taking could have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit?

Height

Weight

Please indicate any health issues that apply for the patient

Patient has been hospitalized in the past year?

☐ Yes ☐ No

If so, describe

Patient has a prosthetic joint or heart valve replacement?

☐ Yes ☐ No

If so, describe

Patient or a family member has had an unusual or serious reaction to general anesthesia?

☐ Yes ☐ No

If so, describe

Patient under the care of a pain management or addiction specialist?

☐ Yes ☐ No

If so, describe

HEALTH HISTORY PART 2

If any of the following categories is YES, please indicate the condition.

Cardiac History

Cardiac History

☐ Yes ☐ No

If yes, please indicate the condition

☐ High Cholesterol ☐ High Blood Pressure (Hypertension) ☐ Heart Attack (Myocardial Infarction) ☐ Angina (Chest pain on exertion)
☐ Irregular Heartbeat ☐ ICD (Implanted Cardiac Defibrillator) ☐ Pacemaker ☐ Heart Surgery ☐ Heart Valve Replacement
☐ Congestive Heart Failure (CHF) ☐ Atrial Fibrillation ☐ Bundle Branch Block or other arrhythmia (irregular heartbeat)

Other

☐ Yes ☐ No

Please specify

Diabetes

Diabetes

☐ Yes ☐ No

If yes, please indicate the condition

☐ Type 1 ☐ Type 2 ☐ Pre-diabetic

Lung Disease

Lung Disease

☐ Yes ☐ No

If yes, please indicate the condition

☐ Asthma ☐ Chronic Bronchitis ☐ Sarcoidosis ☐ Pulmonary Embolism ☐ COPD Emphysema

Other

☐ Yes ☐ No

Please specify

Sleep Apnea

Sleep Apnea

☐ Yes ☐ No

If yes, please indicate the condition

☐ Positive Sleep Study ☐ CPAP ☐ Sleep Appliance

Liver Disease

Liver Disease

☐ Yes ☐ No

If yes, please indicate the condition

☐ Hepatitis ☐ Fatty Liver ☐ Cirrhosis ☐ Liver Failure

Other

☐ Yes ☐ No

Please specify

Kidney Disease

Kidney Disease

☐ Yes ☐ No

If yes, please indicate the condition

☐ Dialysis ☐ Chronic Kidney Failure

Other

☐ Yes ☐ No

Please specify

Thyroid Disease

Thyroid Disease

☐ Yes ☐ No

If yes, please indicate the condition

☐ Hypothyroid ☐ Hashimoto's Disease ☐ Thyroid Removal ☐ Hyperthyroid

Neurologic Disease

Neurologic Disease

☐ Yes ☐ No

If yes, please indicate the condition

☐ Epilepsy / Seizures ☐ Stroke / TIA ☐ Traumatic Brain Injury ☐ Brain Tumors / Surgery ☐ Parkinson's ☐ Myasthenia Gravis
☐ Guillain-Barre ☐ Multiple Sclerosis

Bleeding Issues

Bleeding Issues

☐ Yes ☐ No

If yes, please indicate the condition

☐ Anemia ☐ Clotting Disorder ☐ Von Willebrand's ☐ Factor 5 Deficiency ☐ Sickle Cell ☐ Deep Vein Thrombosis (DVT)

Autoimmune Issues

Autoimmune Issues

☐ Yes ☐ No

If yes, please indicate the condition

☐ Lupus ☐ Rheumatoid ☐ Sjogren's Syndrome

Bone Disorder

Bone Disorder

☐ Yes ☐ No

If yes, please indicate the condition

☐ Osteoporosis ☐ Osteoarthritis

Gastrointestinal Issues

Gastrointestinal Issues

☐ Yes ☐ No

If yes, please indicate the condition

☐ Acid Reflux ☐ Ulcers ☐ Gastric Bypass ☐ Gastric Band

History of Cancer

History of Cancer

☐ Yes ☐ No

If yes, describe

History of Head and / or Neck Radiation

History of Head and / or Neck Radiation

☐ Yes ☐ No

If yes, describe

Where

Developmental Issues

Developmental Issues

☐ Yes ☐ No

If yes, please indicate the condition

☐ Cerebral Palsy ☐ Autism ☐ Blindness or other eye disorders ☐ Deafness

Contagious Diseases

Contagious Diseases

☐ Yes ☐ No

If yes, please indicate the condition

☐ Hepatitis ☐ HIV ☐ AIDS ☐ Tuberculosis

Smoke, Vape or Tobacco Use

Smoke, Vape or Tobacco Use

☐ Yes ☐ No

If yes, please indicate type

☐ Cigarettes ☐ Cigars / Pipe ☐ Chewing Tobacco / Snuff Dipping ☐ Vaping

How many times / packs per day

How long (years)

Marijuana Use

Marijuana - do you use?

☐ Yes ☐ No

Medical Marijuana

☐ Yes ☐ No

If yes for medical marijuana use, for what condition?

Recreational Marijuana

☐ Yes ☐ No

If yes, what types?

☐ Smoke ☐ Vape ☐ Edibles

How many times per week?

Dependency, Mis-Use or Abuse - Current or History

Dependency, Mis-Use or Abuse - Current or History

☐ Yes ☐ No

If yes, please indicate the condition

☐ Alcohol ☐ Prescription Meds (e.g., Vicodin, Percocet, Oxycontin) ☐ Recreational Opioid Drugs (e.g., Heroin, Fentanyl) ☐ Cocaine

Other

☐ Yes ☐ No

Please specify

Are you currently in a care program for this history?

☐ Yes ☐ No

Are you under a contract with your treating provider?

☐ Yes ☐ No

If yes, with whom - First Name

Last Name

Phone

If no, how long have you been in recovery?

Pain Management Program or Recovery Program

Pain Management Program or Recovery Program

☐ Yes ☐ No

If yes, please define

With whom - First Name | Last Name | Phone

Women

Are you or could you be pregnant?

☐ Yes ☐ No

If yes, when is your estimated due date?

If unsure if you might be pregnant, when was your last menstrual cycle?

Other Medical Condition Not Addressed

Other Medical Condition Not Addressed

☐ Yes ☐ No

If yes, describe

Patient / Guardian Signature

Signature | Date

Relationship to patient (if signing for a minor or as guardian)

MEDICATIONS / ALLERGIES

Please list any medications you are currently taking

Medication #1	Dosage	Frequency
Medication #2	Dosage	Frequency
Medication #3	Dosage	Frequency

Medication #4	Dosage	Frequency
Medication #5	Dosage	Frequency
Medication #6	Dosage	Frequency
Medication #7	Dosage	Frequency
Medication #8	Dosage	Frequency
Medication #9	Dosage	Frequency
Medication #10	Dosage	Frequency

☐ I take more than 10 medications

Additional medications (name, dosage, frequency - one per line)

Are you allergic to, or have you had a reaction to:

Penicillin / Amoxicillin
☐ Yes ☐ No

Ibuprofen / Motrin
☐ Yes ☐ No

Sulfa drugs
☐ Yes ☐ No

Codeine or other narcotics
☐ Yes ☐ No

Latex allergy
☐ Yes ☐ No

Please list any other medication or antibiotic you are allergic to or have been advised not to take

Drug #1	Reaction
Drug #2	Reaction
Drug #3	Reaction
Drug #4	Reaction

Drug #5 Reaction

Drug #6 Reaction

Drug #7 Reaction

Drug #8 Reaction

Drug #9 Reaction

List any surgeries, operations, or procedures you have undergone and when

Surgeries / operations / procedures and dates

MEDICAL HEALTH HISTORY ACKNOWLEDGEMENT

☐ **I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.**

Signature Date

If minor, relationship to patient

Fees & Payments Policy

We make every effort to keep down the cost of your 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 charge 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 fill out the proper forms, but please complete the identifying information on this 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 charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys' fees, and court costs.

Signature Oral Surgery is only a part of a coordinated care team that may be required for all of my or the patient's needs. I understand that I would also be responsible for payment for services provided by the general dentist, other dental practitioners, laboratories and pathology services (e.g. review of biopsy specimens), and/or hospitals, clinics and medical providers at other facilities, where I may need follow-up evaluation and additional treatment related to my care at Signature Oral Surgery or any complications I may encounter.

The signature below is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the provider named or the benefits otherwise payable to me. Also, my signature below confirms I understand and agree with the FEES & PAYMENT POLICY as noted above.

☐ **I understand and agree with the Fees & Payments Policy above.**

Authorization Policy

I authorize Signature Oral Surgery, my provider and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment. My signature below confirms I understand and agree with the AUTHORIZATION POLICY for evaluation and treatment noted above.

☐ **I understand and agree with the Authorization Policy above.**

☐ I do NOT want the office to communicate with me via text message to my cell phone.

Consent for Photography / Radiographs

I hereby acknowledge that during the course of my treatment, photographic records and additional radiographic imaging may be taken. These images will be retained as a part of my clinical record. My identity and images will be protected as per corporate policy towards all clinical records. I understand that these images may be used for: research purposes, relevant scientific and dental literature publications, professional website, dental and oral surgical conferences and meeting presentations and for educational purposes with other dental professionals and education of other potential patients that come to our offices. The images may be modified in ethical practices such as realigning, rotating, cropping and color correction such as exposure and contrast.

☐ I understand that images may be taken, however, I do NOT want any images used in publications or presentations.

Cancellation, No Show and Missed Appointments

With the nature of an outpatient surgical office and allocation of time needed for completion of surgical services: missed appointments, "no shows" and last minute cancellations are disruptive to the practice and other patients. You are being advised that you (or the patient) may be dismissed from the practice and unable to make additional appointments if you (or the patient) fail to attend scheduled appointments without notifying the office at least one business day in advance.

I understand that failure to attend scheduled appointments without one business day notice may allow for dismissal from the practice and inability to schedule any future appointments.

☐ Yes ☐ No

Privacy and Personal Representative Authorization for Information Release Policy

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. I understand that a copy of the Privacy Practices is available for me. My signature below confirms I understand and agree with the PRIVACY and PERSONAL REPRESENTATIVE AUTHORIZATION FOR INFORMATION RELEASE POLICY as noted above.

☐ I decline to receive a copy of the office's Notice of Privacy Practices.

Personal Representative Authorization for Information Release

Please list below anyone that you will allow us to discuss this account with and their relationship to you.

First Name	Last Name	Relationship
First Name	Last Name	Relationship
First Name	Last Name	Relationship
First Name	Last Name	Relationship

First Name Last Name Relationship

First Name Last Name Relationship

Signature of Patient (Parent or Guardian if Minor)

☐ **I understand and agree with the Privacy and Personal Representative Authorization policy above.**

Signature Date

Relationship to patient (if signing for a minor or as guardian)