Laurence D. Popowich, D.D.S.
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Niral Parikh, D.D.S., B.D.S.
Oral and Maxillofacial Surgery

VALLEY ORAL SURGERY P.C.

1

Date _____
BP Reading _____

PATIENT INFORMATION RECORD
— PLEASE PRINT —

Date _____

Patient Name _____ How did you hear about us? _____

Social Security # _____ Date of Birth _____ ❑ Male ❑ Female

Home Address _____

City/State/Zip Code _____ Email Address _____

Home Phone _____ Family Dentist _____

Cell Phone _____ Family Physician _____

Employed by _____ Marital Status _____

Occupation _____ Employer Phone _____

Parent/Guardian/Spouse Name _____

Person Responsible for this account _____

In case of emergency, please contact _____ Phone# _____

MEDICAL INSURANCE — COMPLETE ALL FIELDS

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____

If you have secondary medical insurance, please provide the information below. If none, please skip.

2nd Subscriber's Name _____ 2nd Subscriber's Date of Birth _____

2nd Subscriber's Social Security # _____

DENTAL INSURANCE — COMPLETE ALL FIELDS

Subscriber's Name _____ Subscriber's Date of Birth _____

Subscriber's Social Security # _____

If you have secondary dental insurance, please provide the information below. If none, please skip.

2nd Subscriber's Name _____ 2nd Subscriber's Date of Birth _____

2nd Subscriber's Social Security # _____

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MEDICAL HISTORY
— PLEASE PRINT —

Patient Name _____ Date of Birth _____ Date _____

Please complete this Health History so we may provide the best possible care; the doctor will discuss the history with you prior to beginning treatment.

I. General Information

❑ Male ❑ Female Height _____ Weight _____ BP _____

Are you in good health? ❑ Yes ❑ No

Are you now under a physician's care for a particular problem? If so, describe: _____

_____

Physician name and telephone # _____

Date of last physical exam _____

Has there been any change in your general health in the past year? If so, describe: _____

_____

Have you ever had any serious illness? If so, describe: _____

_____

Have you been hospitalized or had surgery during the last 5 years? If so, describe: _____

_____

Have you ever had general anesthesia? ❑ Yes ❑ No

Have you or a family member had any unusal or severe reactions to general anesthesia? ❑ Yes ❑ No

II. Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Low blood pressure				❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Mitral valve prolapse	❑	❑	Delay in healing	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Heart murmur	❑	❑	Hay fever / sinus problems	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / joint disease
❑	❑	Chest pain / Angina	❑	❑	Snoring	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Heart attack(s)	❑	❑	Sleep apnea / CPAP	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Irregular heart beat	❑	❑	Respiratory problems	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Cardiac pacemaker	❑	❑	Tuberculosis	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Heart surgery	❑	❑	Emphysema	❑	❑	Convulsions / epilepsy	❑	❑	Stomach ulcers
❑	❑	Damaged heart valves	❑	❑	Do you smoke	❑	❑	Stroke	❑	❑	GI troubles / IBS / Colitis
❑	❑	Pneumonia / Bronchitis / Chronic Cough			If so, # packs a day_____	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Anemia	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Contact lenses
❑	❑	Asthma	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble			

(FORM CONTINUES ON OPPOSITE SIDE)

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III. Medications & Allergies

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin, aspirin, Eliquis, Pradaxa)
									❑	❑	Are you taking, or have you ever taken, any bone density medications, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 months.

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products).

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin / Amoxicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Latex
❑	❑	Propofol / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Do you have any other known allergies
❑	❑	Soy	❑	❑	Eggs	❑	❑	Sulfites			

Please list any other medication or antibiotic you are allergic to:

MEDICATION/ANTIBIOTIC NAME	MEDICATION/ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

IV. For Women Only

Please answer items 1-4 below. (Women note: antibiotics such as penicilllin may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control).

1) Is there a possibility of pregnancy? ❑Yes ❑No

2) Expected delivery date:_____

3) Are you nursing? ❑Yes ❑No

4) Are you taking birth control pills: ❑Yes ❑No

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.

X _____ **X** _____ **X** _____ **X** _____

Signature of patient *(Parent or guardian, if minor)* **Date** **Reviewed by** **Date**

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COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

READ BEFORE SIGNING THE ACKNOWLEDGEMENT AND CONSENT

This acknowledgement of notice and consent authorizes Valley Oral Surgery to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices. Valley Oral Surgery has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

HOW TO CONTACT OUR PRIVACY OFFICER

Mail: Valley Oral Surgery
Attention: Privacy Officer
1275 S. Cedar Crest Blvd., Suite 1
Allentown, PA 18103
Telephone: 610-437-1727
Facsimile: 610-437-4715

ACKNOWLEDGEMENT AND CONSENT (PRINT OR TYPE ALL INFORMATION EXCEPT SIGNATURE)

I have received the Notice of Privacy Practices for Valley Oral Surgery and authorize them to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient (or patient's personal representative) Date

Personal representative information (if applicable):

_____ _____
Name of personal representative Relationship to patient (or other authority)

(FORM CONTINUES ON OPPOSITE SIDE)

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COMMUNICATION CONSENT

It is the office policy of Valley Oral Surgery, PC and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and/or cell phone. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Valley Oral Surgery, PC and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone _____

Answering Machine _____

Work Telephone _____

Voice Mail _____

Cell Phone and/or Voice Mail _____

E-mail _____

If you would like to have information released to someone other than yourself please complete the following:

Please list names of authorized people:

_____ Relationship:_____

_____ Relationship:_____

In order for us to manage/service your account or to collect monies you may owe, Valley Oral Surgery, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone, which may result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device as applicable.

Printed Name _____

Patient/Guardian Signature: _____ Date: _____

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FINANCIAL POLICY

Valley Oral Surgery participates with many insurance plans and will file your claim for you. As a courtesy to our patients, Valley Oral Surgery will contact your insurance company to establish an **ESTIMATE** of benefits, deductible and/or copayments based on the proposed treatment plan. Information given to us by your insurance company is an **ESTIMATE** and **DOES NOT** guarantee coverage or payment.

Please be aware that some procedures may not be covered or considered medically necessary by your insurance carrier. At the time of your consultation, financial arrangements will be openly discussed. Please note financial obligations for the treatment rendered are the patient's responsibility.

For your convenience, we accept the following methods of payment: Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit.

Valley Oral Surgery offers completion of forms as an added service to patients. We have the following policy in place as outlined below:

Instructions:

- Pre-payment of $15 per form is required.
- The following forms will be assessed a $15 fee for completion:
  - FMLA
  - Disability / Life Insurance
  - Letter of condition
  - Miscellaneous patient requests
- Patient must complete all of their information on the form prior to submitting to the office.
- Forms must be requested well in advance of when they are needed. We will attempt to complete the forms as quickly as possible, but please allow 5-7 business days.
- Provide a stamped, addressed envelope to expedite mailing of completed forms.

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.

X _____ X _____ X _____ X _____

Signature of patient *(Parent or guardian, if minor)* **Date** **Reviewed by** **Date**

AUTHORIZATION

I authorize my surgeon 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.

X _____ X _____ X _____

Signature of patient *(Parent or guardian, if minor)* **Doctor** **Date**