

# The Implant & Oral Surgery Center

## PATIENT INFORMATION

**PLEASE PRINT:**

NAME(Mr/Mrs/Ms) \_\_\_\_\_  
(First) (Nickname) (M.I.) (Last)

## PERSON FINANCIALLY RESPONSIBLE

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

**Dental Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Dental Insurance Address: \_\_\_\_\_

Dental Insurance Phone #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

**Health Insurance:** \_\_\_\_\_ Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Health Insurance Address: \_\_\_\_\_

Health Insurance Phone #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Insured SS#: \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

## PLEASE PROVIDE COPIES OF YOUR INSURANCE CARDS

\_\_\_\_\_  
Patient/Parent or Guardian Signature

\_\_\_\_\_  
Date

**Consent for Use and Disclosure of Personal Health Information and Patient Imaging**

This form authorizes Dr. Daniel Esposito, Dr. Jeremy Miner and staff to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

Please Initial each paragraph:

\_\_\_\_\_ I have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

\_\_\_\_\_ I hereby authorize Dr. Esposito, Dr. Miner and staff to take clinical photographs, videos or digital images of my condition, both before and after treatment. These images may be presented to scientific, medical and similar groups, and/or printed in journal and publication for teaching of education purposes. In certain cases other prospective patients may view them. Although the images will not be labeled with my name, I am aware that certain images may reveal my identity. All images remain the property of Dr. Esposito or Dr. Miner and may be used in the future unless I specifically notify Dr. Esposito or Dr. Miner in writing that I do not wish the images to be shown.

**Acknowledgement of Receipt of Notice of Privacy Policies**

\_\_\_\_\_ I have received a copy of the Notice of Privacy Policies.

I have read and understand the preceding paragraphs:

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Patient/Parent or Guardian

Date

For questions concerning our Notice of Privacy Policies, please contact:  
Zola Redell, Office Manager. You may reach her by calling (303) 933-8282 ext. 203.

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**

## Review of Systems

Please take the time to carefully complete the following questions. Accurate completion will greatly aid in the safe and efficient performance of your surgical procedure.

Have recently experienced any of the following symptoms? If you experience these symptoms on a regular basis, have you experienced any changes to their frequency or severity?

<b>Fever</b>	Y	N	No change	Moderate change	Severe Change
<b>Chills</b>	Y	N	No change	Moderate change	Severe Change
<b>Nausea</b>	Y	N	No change	Moderate change	Severe Change
<b>Vomiting</b>	Y	N	No change	Moderate change	Severe Change
<b>Diarrhea</b>	Y	N	No change	Moderate change	Severe Change
<b>Cough</b>	Y	N	No change	Moderate change	Severe Change
<b>Trouble Breathing</b>	Y	N	No change	Moderate change	Severe Change
<b>Trouble Sleeping</b>	Y	N	No change	Moderate change	Severe Change
<b>Chest Pain</b>	Y	N	No change	Moderate change	Severe Change
<b>Leg Pain</b>	Y	N	No change	Moderate change	Severe Change
<b>Blood in Urine</b>	Y	N	No change	Moderate change	Severe Change
<b>Blood in Stool</b>	Y	N	No change	Moderate change	Severe Change
<b>Blood from Cough</b>	Y	N	No change	Moderate change	Severe Change
<b>Constipation</b>	Y	N	No change	Moderate change	Severe Change
<b>Loss of Vision</b>	Y	N	No change	Moderate change	Severe Change
<b>Ringing in Ears</b>	Y	N	No change	Moderate change	Severe Change
<b>Painful Urination</b>	Y	N	No change	Moderate change	Severe Change
<b>Painful Swallowing</b>	Y	N	No change	Moderate change	Severe Change

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# The Implant and Oral Surgery Center

*Please answer all questions as completely as possible.*

Please Print

## HEALTH HISTORY

Name: \_\_\_\_\_  
(First) (Nickname) (M.I.) (Last)

Address: \_\_\_\_\_ City/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Business \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M \ \ F SSN: \_\_\_\_\_

Dentist: \_\_\_\_\_ Referred by: \_\_\_\_\_

Physician: \_\_\_\_\_ Physician phone: \_\_\_\_\_

IN CASE OF EMERGENCY PLEASE CONTACT: NAME: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

Have you ever had any of the following? (Check YES or NO)

	YES	NO		YES	NO		YES	NO
Angina/Chest pain			Epilepsy			Kidney Disease		
Arthritis			Heart Attack			Pacemaker		
Asthma			Heart Disease			Rheumatic Fever		
Bleeding Problems			Heart Murmur			Shortness of Breath		
Blood Clots			Heart Surgery			Surgery		
Cancer			Hepatitis			TB		
Diabetes			Hypertension			Thyroid		
Dialysis			Immune Problems			TM Joint Problem		
Emphysema			Joint Implant			Other *		

Heart Problems: \_\_\_\_\_

Surgery: \_\_\_\_\_

Have you EVER had an allergic reaction to drugs or food: NO \ \ YES (indicate which drugs/food):

Penicillin \ \ Sulfa \ \ Codeine \ \ Novocaine \ \ Aspirin \ \ LATEX \ \ PEANUTS

Other: \_\_\_\_\_

List all medications you CURRENTLY take, including birth control pills and/or bisphosphonates such as:

Didronel, Skelid, Fosamax, Actonel, Boniva, Aredia or Zometa--- use separate sheet if needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Social History: (Past or Current)**

Tobacco use: \_\_\_\_\_ packs per day for \_\_\_\_\_ years. Alcohol use: \_\_\_\_\_

Education History: HS Diploma \_\_\_\_\_ College \_\_\_\_\_ Graduate School \_\_\_\_\_ Other \_\_\_\_\_

School Name: \_\_\_\_\_ Military History: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### **Family Medical History:**

Marital Status: \_\_\_\_\_ Children: \_\_\_\_\_

Cancer: \_\_\_\_\_ Heart Disease: \_\_\_\_\_ Other: \_\_\_\_\_

Notes: \_\_\_\_\_

Are you currently under the care of a physician? If yes please explain: \_\_\_\_\_

Are you now, or could you be pregnant? YES \ \ NO If yes, when due? \_\_\_\_\_

Date of your last physical exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you ever received radiation therapy of the head, face or jaws? YES \ \ NO

If YES, please explain: \_\_\_\_\_

**Patient/Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Use Only:**

Reviewed By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Health History Update & Review:** Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

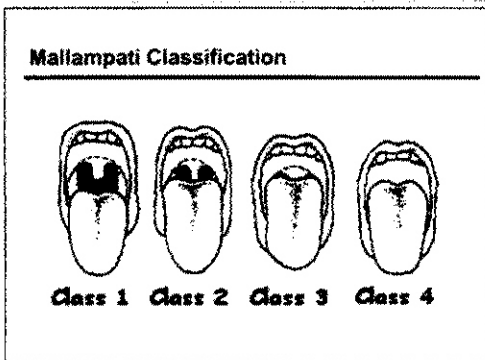
Vital Signs

BP \_\_\_\_\_ P \_\_\_\_\_ O2 \_\_\_\_\_ R \_\_\_\_\_

ASA Class \_\_\_\_\_ MP Class \_\_\_\_\_ MIO Class \_\_\_\_\_

Thyromental distances is greater than 6.5 cm \_\_\_\_\_

Whats most important to you regarding your dental health? \_\_\_\_\_



**ASA Classifications\***

- P1 A normal healthy patient
- P2 A patient with mild systemic disease
- P3 A patient with severe systemic disease
- P4 A patient with severe systemic disease that is a constant threat to life

\*<http://www.asahq.org/clinical/physicalstatus.htm>