WELCOME TO THE DOWNRIVER SURGERY CENTER

Have you ever been a patient of our practice? Yes No Method of Personal Payment: Cash Check Credit Card

Date:____________

Patient: (Mr., Mrs., Ms., Dr.) First Name__________________M.I.___ Last Name_____________________Nickname___________

Sex: Male Female Date of Birth_______________________ Age____ Social Security #____________________________

Street____City_________________________State_____________Zip ____________

Home Tel.# (___) _______________E-mail Address________________________________ Cell Phone ______________________

Business Tel. # (___) ________________ Ext.___________ Employer ____

Dentist_____________Ph. #__________ Medical Doctor_____________Ph. #__________ Referred by __________Ph. #________

Driver's Lic. #__________________________ Nearest relative not living with you________________________Tel. #(___) _______

Who will be responsible for your account? Self Spouse Father Mother Other ________________________
(If self, skip to next paragraph)

Name______________________________Soc. Sec.____________________Birth Date__________ Home Tel.: (___) ____________

Street____City___________________________State____________Zip ___________

Employer____ Tel.: (___) ________________

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes No _______________________

Is there a **family history** of**: Cancer** Yes No **Diabetes** Yes No **Heart Disease** Yes No **Anesthetic Problems** Yes No

IN CASE OF EMERGENCY, CONTACT: Name______________________ Tel # H: (___) ________________ Wk: (___) ___________________

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: Yes No Work Related: Yes No Other: Yes No

Date of Injury:______________ Insurance Co. handling this claim:______________________________ Claim #:_________________

Name of Attorney / Adjustor____Tel #: (___)_______________

____

PRIMARY DENTAL INSURANCE COMPANY

Employer ____

Ins. Co. Name ____

Address ____

____________________________ Phone: (___) ______________

Group #:____

Policyholder_____________________ Relation _______________

Sex: M F

Date of Birth: ____

I.D. #:_____________________S.S.#: ______________________

PRIMARY MEDICAL INSURANCE COMPANY

Employer ____

Ins. Co. Name ____

Address ____

____________________________ Phone: (___) ______________

Group #:____

Policyholder_____________________ Relation _______________

Sex: M F

Date of Birth: ____

I.D. #:_____________________S.S.#: ______________________

SECONDARY DENTAL INSURANCE COMPANY

Employer ____

Ins. Co. Name ____

Address ____

____________________________ Phone: (___) ______________

Group #:____

Policyholder_____________________ Relation _______________

Sex: M F

Date of Birth: ____

I.D. #:_____________________S.S.#: ______________________

SECONDARY MEDICAL INSURANCE COMPANY

Employer ____

Ins. Co. Name ____

Address ____

____________________________ Phone: (___) ______________

Group #:____

Policyholder_____________________ Relation _______________

Sex: M F

Date of Birth: ____

I.D. #:_____________________S.S.#: ______________________

HEALTH HISTORY

TO OUR PATIENTS: Health problems that you may have or medications that you may be taking, could have an important interrelationship with the care that 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:____

____

____

A.		Yes	No
1.	Are you in good health? .... Height ______________ Weight ____________		
2.	Have there been any changes in your general health in the past year? _________________		
3.	Are you under the care of a physician?.........................Date of last visit: ________________		
	If so, for what are you being treated?____		
4.	Have you had any serious illness, operations or hospitalizations? If so, describe...................		
	____		
5.	Do you have a prosthetic joint/implant?If so, described where_________________________		
6.	Have you had a heart valve replacement or vascular graft?..		

B.

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES
1	Rheumatic fever?			
2	Damaged heart valves ? mitral valve prolapse?			
3	Heart murmur?			
4	High Blood Pressure?			
5	Low Blood Pressure?			
6	Chest Pain, angina			
7	Heart attack(s)?			
8	Irregular heart beat?			
9	Cardiac pacemaker?			
10	Heart surgery?			
11	Bronchitis, chronic cough?			
12	Asthma?			
13	Hay fever / Sinus problems?			
14	Tuberculosis?			
15	Emphysema?			
16	Difficult breathing / other lung trouble			
17	Do you smoke?			
18	Blood transfusion?			
19	Blood disorder such as anemia?			
20	Bruise easily?			
21	Bleeding tendency (abnormal bleed?)			
22	Jaundice, hepatitis or liver disease?			
23	Infectious Mononucleosis?			
24	Gallbladder trouble?			
25	Fainting spells?			
26	Convulsions, epilepsy?			

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES
27	Stroke?			
28	Thyroid trouble?			
29	Diabetes?			
30	Low blood sugar?			
31	Kidney trouble?			
32	Are you on dialysis?			
33	Swollen ankles, arthritis or joint disease?			
34	Stomach ulcers?			
35	Contagious diseases?			
36	Sexually transmitted diseases?			
37	Problems with the immune system?			
38	Delay in healing?			
39	A tumor or growth?			
40	X-Ray treatment / chemotherapy?			
41	Chronic fatigue / night sweats?			
42	Are you on a diet?			
43	A history of drug abuse?			
44	A history of alcohol abuse?			
45	Contact lenses?			
46	Eye disease / glaucoma?			
47	Mental health problems?			
48	A removable dental appliance?			
49	Pain & Clicking of jaws when eating?			
50	Malignant Hyperthermia?			
51	Have you had anything to eat or			
52	Who is driving you home today?			

C. MEDICATION

ARE YOU NOW TAKING...	Yes	No	Notes	ARE YOU NOW TAKING...	Yes	No	Notes
1. Any kind of medicine, drugs, or pills?				4. Tranquilizers?			
2. Anticoagulants?				5. Cortisone?			
3 Diet Pills?				6. Other medications (please list)?			

D. ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Ye	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Ye	No	Notes
7. Local anesthetics?				12. Codeine or other narcotics?			
8. Penicillin?				13. Other medications?			
9. Other antibiotics?				14. Allergies other than drug allergies			
10.Sodium pentothal, valium, or other tranquilizers?				(please list)			
11. Aspirin?							

E. WOMEN

15. Is there a possibility of pregnancy?				17. Are you nursing?			
16. Estimated delivery date __/__/__				18. Are you taking birth control pills?			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

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 surgeon, or any other member of his I her staff, responsible for any errors or omissions that I have made in the completion of this form.

Initials: ____

FEES & PAYMENTS

We make every effort to keep down the cost of your surgical 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. In order to assure a response form your insurance company within the allowed time of 30 days, any claim that is not responded to within 30 days is subject to a complaint against the insurance company. Your signature authorization will permit us to write to the insurance commissioner, which will expedite your reimbursement.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Initials: ____

AUTHORIZATION

I authorize my surgeon and his I her designated staff, to perform an 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

Initials: ____

Date ____

Signature of Patient ____
(Parent or Guardian if minor)

Witness: ____

Doctor: ____