SANTARELLI & TIBORIS
ORAL & FACIAL SURGERY s.c.

PATIENT PERSONAL & INSURANCE INFORMATION

Welcome to our office. So that we may assist you in completing your medical and dental insurance forms, please provide us with the information required below. All information is confidential.

SANTARELLI & TIBORIS
ORAL & FACIAL SURGERY s.c.

PATIENT INFORMATION

PATIENT'S NAME _____ TODAY'S DATE _____

BIRTHDATE _____ / _____ / _____ AGE _____ SEX _____ SOC. SEC. # _____ - _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

MAY WE LEAVE A DETAILED MESSAGE ON YOUR ANSWERING MACHINE IF NEEDED? YES NO

WORK PHONE _____ EMAIL _____

EMPLOYER/SCHOOL NAME & ADDRESS _____ FULL TIME STUDENT YES NO

FAMILY PHYSICIAN _____ GENERAL DENTIST _____

REFERRED BY _____

REASON FOR VISIT _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION (if minor)

NAME _____ MARITAL STATUS _____
LAST FIRST MIDDLE

RESIDENCE _____
STREET CITY STATE ZIP

MAILING ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE ( ) _____ WORK PHONE ( ) _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SOCIAL SECURITY # _____ BIRTHDATE _____ WORK PHONE ( ) _____

INSURANCE INFORMATION

INSURED'S NAME _____ BIRTHDATE ____ /____ /____ SOC. SEC. # _____
LAST FIRST MIDDLE INITIAL

EMPLOYER'S NAME _____

INSURANCE COMPANY _____ GROUP # _____ ID # _____

DO YOU HAVE DUAL COVERAGE? _____ IF YES _____

INSURED'S NAME _____ BIRTHDATE ____ /____ /____ SOC. SEC. # _____
LAST FIRST MIDDLE INITIAL

EMPLOYER'S NAME _____

INSURANCE COMPANY _____ GROUP # _____ ID # _____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH THE PATIENT _____

COMPLETE ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE ( ) _____ SPECIAL NOTES _____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Santarelli and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

I understand that where appropriate, credit bureau reports may be obtained.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ **DATE** _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)

HEALTH HISTORY

Patient's Name | Date of Birth | Height | Weight | Date

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

_____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? ..... Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis? ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - P. Radiation (X-ray) treatment for Cancer? ..... Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - R. Sinus or Nasal problems? ..... Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ..... Y N
   - F. Tranquilizers? ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ..... Y N
     If so for how long and what is your dosing? _____

_____

_____

   - J. Have you ever been advised <u>not</u> to take a medication? ..... Y N

_____

   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

_____

_____

_____

_____

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber products? ..... Y N
   - G. Metal of any kind? ..... Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ..... Y N
   - I. Food products? ..... Y N
   - J. Other allergies or reactions? Please list ..... Y N

_____

_____

_____

9. Do you smoke or chew Tobacco? ..... Y N
   How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
11. Have you had any serious problems associated with any previous dental treatment? ..... Y N

_____

12. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N

_____

13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N

_____

14. Do you wish to talk to the doctor privately about anything? ..... Y N

_____

15. Have you ever had a bone density scan? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

(Continue on the back of this page)

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date	Signature of Person Completing Health History	Doctor's Initials

Chief Dental Complaint: _____

_____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____

Santarelli & Tiboris Oral & Facial Surgery, SC

Wisconsin Consent

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's surgical care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's surgical care records to carry out treatment, payment activities, and health care operations.

Section A: Individual giving consent

***Name:_____

***Patient Name:_____

***Address:_____

***Telephone:_____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our surgical office's *Notice of Privacy Practices* accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Section B: The uses and disclosures being authorized.

Our use of Dental Health Information: By signing this form, you will consent to our use of your surgical care records, to carry out treatment, payment activities, and health care operations as set forth in our *Privacy Practices Notice*.

Persons Involved in Care: By signing this form, you will consent to our use of your surgical care records to the following persons, including those involved in your care or payment for that care.

***Please list person(s) you would like involved in your care or payment for that care:**

_____ _____

_____ _____

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information: By signing this form, you will consent to our disclosure of your surgical care records to carry out treatment, payment activities, and health care operations as set forth

in our *Privacy Practices Notice*, and to our disclosure of your surgical care records for disaster relief purposes as permitted by law.

Section C: Revocation:

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Officer listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Officer: Joya Santarelli

Address: 5021 Washington Road, Kenosha, WI 53144

Telephone: 262-654-6770

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

***Signature_____ Date_____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

***Personal Representative/Parent Name:_____

***Relationship to Individual:_____

Santarelli & Tiboris Oral & Facial Surgery, SC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____
_____
_____

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).