

PAUL M. KORB D.M.D., P.C.

PATIENT INFORMATION

NAME _____ PREFERRED NAME _____ DOB _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ WK PHONE _____ CELL _____

SOCIAL SECURITY # _____ IF STUDENT SCHOOL/ COLLEGE _____

PERSON TO CONTACT IN EMERGENCY _____ PHONE _____

HAS ANYONE IN YOUR FAMILY BEEN SEEN IN THIS OFFICE? (IF YES, WHO?) _____

WHOM MAY WE THANK FOR REFERRING YOU _____

NAME OF YOUR GENERAL DENTIST _____ LAST VISIT _____

RESPONSIBLE PARTY

NAME _____ RELATION TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

EMPLOYER _____ WORK PHONE _____

SOCIAL SECURITY # _____

INSURANCE INFORMATION

SUBSCRIBER (INSURED) _____ RELATION _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

MEDICAL INSURANCE COMPANY _____

DENTAL INSURANCE COMPANY _____

**** PLEASE PROVIDE COPY OF INURANCE CARDS TO FRONT DESK****

IF THERE ARE ANY CHANGES IN THE PATIENT STATUS OR INSURANCE INFORMATION, I WILL CONTACT PAUL M. KORB D.M.D. WITH CURRENT INFORMATION.

SIGNATURE OF PATIENT OR PARENT IF MINOR

DATE

HEALTH HISTORY

Patient's Name	Date of Birth	Height	Weight	Date
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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

- I. Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ? Y N
- J. Have you ever been advised not to take a medication? 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

- 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

- 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

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 is there any chance 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.

**Paul M. Korb, D.M.D., PC
Oral & Maxillofacial Surgery**

FINANCIAL ARRANGEMENTS

We realize that every person's financial situation is different. For this reason we have worked hard to provide a variety of payment options to help you receive the oral & maxillofacial surgery care you need with respect to your budget.

We accept payments by Cash, Check, MasterCard, Visa, Discover and American Express.

A 5% professional courtesy is offered for all treatment paid in full, 5 days prior to surgery with cash or check.

For patients who desire a monthly payment plan we have made arrangements with a finance company. Care Credit offers no application fees, no down payments, and the loan can be interest-free. Information is available upon your request.

INSURANCE

*The insurance policy is an agreement between you and your insurance company; all patients are directly responsible for all charges. As a courtesy, we will file the forms necessary for you to receive your insurance benefits; however we **make no guarantee of any estimated coverage.** If for any reason your insurance company has not paid their portion within six weeks from the date of treatment, **you are responsible for the full balance.***

PLEASE NOTE:

Due to the significant preparation required by our office to safely perform your surgery, there will be a non-refundable charge of ten percent (10%) of the estimated surgery total in the event that your procedures must be rescheduled with less than three (3) full working days notice. This charge is not covered by your insurance.

PRIVACY POLICY

With your consent, this practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. I agree to abide by this notice of privacy practice for protected health care information. The Hipaa Privacy Policy can be made available upon my request. This consent shall not expire.

Patient or Responsibility Signature, Date