N O R T H E A S T

Oral & Maxillofacial Surgery Center
9310 Two Notch Road Columbia, SC 29223 (803) 699-5900

Diplomats, American Board of Oral and Maxillofacial Surgery

Jeffery Dootson, DMD **Stephen E. Clary, DDS**
James W. Strider, Jr., DMD

Our staff would like to welcome you to our office. Please answer all questions listed below as this information will help us serve you better. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask us to clarify it for you.

Name (Mr. ☐ Mrs. ☐ Ms. ☐)_____ _____ _____
last **first** **m.i.**

Name (or nickname) you wish to be called _____

Street _____

City _____ State _____ ZIP Code _____

Social Security Number _____ Drivers License # _____

Student (Full Time☐ Part Time☐)

School Name_____ _____ _____ _____ _____
street city state zip

Date of Birth_____Who referred you to this office? _____ _____
First Name Last Name

Occupation:_____Work Phone(_____)_____Home phone (_____)_____

Employer _____ Address _____ Zip Code _____

Name of Spouse _____ Employer _____

Nearest relative not living with you _____ _____Relationship_____
First Name Last Name

Address _____ Phone(_____)_____

(Only if different than above)

Name of person responsible for payments _____ _____
First Name Last Name

Address_____City_____State_____Zip Code_____

Occupation:_____Work Phone(_____)_____Home phone (_____)_____

Employer _____ Address _____ Zip Code _____

Name of Spouse _____ Employer _____

PLEASE INDICATE BELOW HOW YOU PREFER TO PAY FOR YOUR TREATMENT

Cash _____ **Personal Check** _____ **Credit Card Number** _____

INSURANCE INFORMATION:

Employee Carrying Insurance_____ _____Employee Birth Date_____
First Name Last Name

Employee Social Security # _____ Group Policy # _____

Insurance Company Name _____ Phone Number)_____*_____

(over)

ADDITIONAL INSURANCE COVERAGE:

Employee Carrying Insurance_____ _____Employee Birth Date_____
First Name Last Name

Employee Social Security #_____ Policy Number _____

Insurance Company Name _____ Phone Number)_____*_____

Signature on File _____ Patient's Name_____

While we will be happy to assist you in the filing of any insurance claims, it must be understood that insurance reimbursement performance is a matter between you and your insurance company. In cases where benefits are assigned to our office, we will wait a maximum of 30 days for payment. After that time, the balance will be due in full, payable by the method you have chosen on the front page of this document.

I understand the policy described here concerning insurance reimbursement and agree to comply with the stated policy.

SIGNED _____ **DATE** _____

I authorize release of any information necessary to process my insurance claims.

SIGNED _____ **DATE** _____

I hereby authorize payment directly to **NORTHEAST ORAL & MAXILLOFACIAL SURGERY CENTER, P.A.** the group benefits otherwise payable to me.

SIGN _____ **DATE** _____

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MEDICAL HEALTH HISTORY

Name: _____ Name you would like to be called: _____
(Last) (First) (Middle)

Date: _____ Home Phone: _____ Work Phone _____ Date of Birth: _____

Reason for visit: _____

Personal Physician: _____ _____ Personal Dentist: _____ _____
First Name Last Name First Name Last Name

Referred by: _____ Age _____ Sex _____ Height _____ Weight _____ lb.

Please check appropriate response and give details below for positive responses:

Yes	No		Yes	No	
☐	☐	ALLERGIES (FOOD, LATEX GLOVES ETC.)	☐	☐	HEART DISEASE
☐	☐	DRUG SENSITIVITIES	☐	☐	HEART MURMUR
			☐	☐	RHEUMATIC FEVER
☐	☐	ASTHMA	☐	☐	HIGH BLOOD PRESSURE
☐	☐	TUBERCULOSIS			
☐	☐	BREATHING PROBLEMS	☐	☐	DIABETES
			☐	☐	KIDNEY DISEASE
☐	☐	HEPATITIS			
☐	☐	LIVER DISEASE	☐	☐	SEIZURE DISORDER (EPILEPSY)
☐	☐	ANEMIA	☐	☐	FAINTING OR DIZZY SPELLS
☐	☐	UNUSUAL BLEEDING	☐	☐	VERTIGO (LOSS OF BALANCE)
☐	☐	BLOOD TRANSFUSION	☐	☐	HISTORY OF CANCER/TUMOR
☐	☐	ULCERS (PRESENTLY or PREVIOUSLY)	☐	☐	RADIATION THERAPY
☐	☐	GI DISTURBANCES	☐	☐	PROBLEMS WITH ANESTHESIA
☐	☐	DO YOU TAKE ASPIRIN PRODUCTS REGULARLY	☐	☐	DO YOU USE TOBACCO PRODUCTS
☐	☐	CURRENTLY TAKING BISPHOSPHONATES	☐	☐	HISTORY OF HIV OR AIDS
		(AREDIA,ZOMETA,FOSAMAX,ACTONEL)	☐	☐	WOMEN: ARE YOU PREGNANT?

LIST ALL PREVIOUS SURGICAL PROCEDURES AND HOSPITALIZATIONS:

LIST ALL MEDICATIONS YOU ARE CURRENTLY USING:

EXPLANATIONS FOR YES RESPONSES:

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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

THIS COMPLETED FORM WILL BE AVAILABLE TO SIGN IN OFFICE AT THE TIME OF YOUR APPOINTMENT.

For Office Use Only

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

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

_____

_____