michael**borenstein**, d.d.s.

Oral and Maxillofacial Surgeon
Diplomate, American Board of Oral and Maxillofacial Surgery

Welcome To Our Practice

Patient: First Name_________________ M.I._______ Last Name_________________

Street Address_________________ Apt.#________ City_____________ State______ Zip_______

Date of Birth_____________ Social Security #_________________ Sex: M F Age________

Email_________________ Are you a new patient? Y N Marital status______________

Home Tel. # (______)_________________ Mobile # (______)_________________

Employer / School Name_________________ Occupation_________________

Employer / School Address_________________

Business Tel. # (______)_________________ ext____________

Employed: Full Time Part Time Retired Not Presently Employed

Emergency Contact: _________________ Relation_________________

Home Tel. # (______)_________________ Mobile # (______)_________________

Reason for today's visit:_________________ Referred By_________________

Dentist Name:_________________ Dentist Tel. # (______)_________________

Physician Name:_________________ Physician Tel. # (______)_________________

Pharmacy Name:_________________ Pharmacy Tel. # (______)_________________

Method of Payment: Cash Check Credit Card

Dental Insurance Company_________________ Are you the Member? Y N

Medical Insurance Company_________________ Are you the Member? Y N

Insurance Member's information: Name_________________ Relation_________________

Street Address_________________ Apt.#________ City_____________ State______ Zip_______

Social Security #_________________ Date of Birth_____________ Home Tel. # (______)_________________

Employer_________________ Tel. # (______)_________________

Please give your Dental & Medical Insurance cards, x-ray and Dentist referral to the front desk

HEALTH QUESTIONNAIRE FORM

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I. General Information

Name: ______________________________ Date: ______________

Reason for today's office visit: ______________________________

To Our Patients: Although oral surgeons treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential

☐ Yes ☐ No Are you in good health? Height: __________ Weight: __________

☐ Yes ☐ No Have there been and changes in your general health in the past year?
____

☐ Yes ☐ No Are you under the care of a physician? Date of last visit: __________
If YES, for what are you being treated? ______________________________

☐ Yes ☐ No Have you had any illness, operation, or been hospitalized in the past five years?
If YES please list: ______________________________

Have you had or do you currently have ...			
	YES	NO	NOTES
Anemia	☐	☐	
Anesthetic Problems (Family History)	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding Tendency	☐	☐	
Blood Transfusion	☐	☐	
Bronchitis, Chronic Cough	☐	☐	
Cancer	☐	☐	
Cardiac Pacemaker	☐	☐	
Chemotherapy or Radiation	☐	☐	
Contact Lenses	☐	☐	
Contagious Disease	☐	☐	
Convulsions	☐	☐	
Delay in Healing	☐	☐	
Diabetes	☐	☐	
Dialysis	☐	☐	
Difficulty Breathing	☐	☐	
Emphysema	☐	☐	
Epilepsy	☐	☐	
Eye Disease	☐	☐	
Fainting Spells	☐	☐	
Gallbladder Trouble	☐	☐	
Hay Fever/Sinus Problems	☐	☐	
Heart Attack/Chest Pain	☐	☐	
Heart Disease (Family History)	☐	☐	
Heart Murmur/Artificial Valves	☐	☐	
Heart Surgery	☐	☐	

Have you had or do you currently have ...			
	YES	NO	NOTES
High Blood Pressure	☐	☐	
History of Drug/Alcohol Abuse	☐	☐	
Infection	☐	☐	
Irregular Heart Beat	☐	☐	
Jaundice, Hepatitis, Liver Disease	☐	☐	
Kidney Trouble	☐	☐	
Low Blood Pressure	☐	☐	
Low Blood Sugar	☐	☐	
Malignant Hyperthermia	☐	☐	
Mental Health Problems	☐	☐	
Mitral Valve Prolapse	☐	☐	
Are you pregnant/nursing?	☐	☐	
(estimated due date)			
Problems with Immune System	☐	☐	
Prosthetic Knee/Hip etc.	☐	☐	
Removable Dental Appliance	☐	☐	
Rheumatic Fever	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Smoker	☐	☐	
Sore in Mouth	☐	☐	
Stomach Ulcers	☐	☐	
Stroke	☐	☐	
Swollen Ankles	☐	☐	
Thyroid Trouble	☐	☐	
TMJ-Pain & Clicking of Jaws	☐	☐	
Tuberculosis	☐	☐	
Tumor or Growth	☐	☐	

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Name: ______________________________ Date: ______________

II. Allergy Information

	YES	NO	NOTES			YES	NO	NOTES
Local Anesthetic	☐	☐			Codeine or other Narcotics	☐	☐	
Penicillin	☐	☐			Other Medications	☐	☐	
Sodium Pentothal, Valium or other Tranquilizers	☐	☐			*(Please List)*			
Aspirin	☐	☐			Allergies other than Drug Allergies	☐	☐	
					Latex Allergy	☐	☐	
					Food Allergies	☐	☐	

III. Medication Information

	YES	NO				YES	NO	NOTES
Birth Control	☐	☐				☐	☐	
Anticoagulant (Blood Thinners)	☐	☐				☐	☐	

List all medications, drugs, or pills:

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

IV. Osteoporosis / Bone Strengthening Medication

☐ Yes ☐ No Have you ever taken medication (by mouth or IV) to strengthen your bones or to make them more dense? (Examples include: Fosamax, Boniva, Aredia, Prolia, Actonel, and Reclast). If YES please explain:

V. Miscellaneous

☐ Yes ☐ No Is there any condition concerning your health that the Doctor should be made aware of?
If YES please explain:

☐ Yes ☐ No Is this visit related to an accident?

Type of Accident: ______________________________

Date of Injury . ______________________________

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 staff, responsible for errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature: **Date:**

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MEDICARE/INSURANCE SUPPLEMENT

This office is not a provider for any Dental, Medical, or Medicare insurance carriers. As a courtesy, we will submit a claim to your insurance company (EXCEPT MEDICARE), and any reimbursement will be sent directly to the insured.

Patient ____

Signature ______________________________ Date __________

Michael C. Borenstein, D.D.S. ____________________ Date __________

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name ____

Last First MI Maiden or Other Name

Date of Birth ______-______-______ Medical Record # ____________________ Phone____________________

Address______________________________ City____________________ State________ Zip__________

Date of Service ____

I authorize Dr. __________________________ to use and disclose my protected health information for his/her own purposes of treatment, payment, and health care operations.

I authorize Dr. __________________________ to disclose the following record related to the date above:

Records:

- ☐ All Records
- ☐ Medical Records
- ☐ Diagnostic Records (lab, x-ray, etc.)
- ☐ Treatment Records
- ☐ Billing/Claims Records
- ☐ HIV/STD
- ☐ Drug and alcohol related

Please note: Revocations do not apply to information that has already been disclosed prior to revocation being received.

You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity.

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on ________________________________

____ ________________________________
Patient or Legal Representative Signature Date

____
Print Patient or Legal Representative Name/Relationship