Western Branch
Oral and Maxillofacial Surgery

PATIENT INFORMATION: Dr. Brian Szakaly, D.D.S.

Patient Name:	Social Security Number:	Today's Date:

Home Address:	City:	State:	Zip Code:

Date of Birth:	Sex: M F	Age:	Marital Status:	Home Phone Number:	Cell Phone Number:	Student? Yes No

Employer:	Work Phone Number:

Employer Address:	City:	State:	Zip Code:

DENTIST:	PHYSICIAN:	REFERRED BY:

Nearest Relative/Friend (Emergency Contact):	Phone Number:

Address:	City:	State:	Zip Code:

PRIMARY RESPONSIBLE PARTY: (Complete if different than Patient Information):

Relationship to Patient:	Name:	Social Security Number:

Address:	City:	State:	Zip Code:	Home Phone Number:	Cell Phone Number:

Date of Birth:	Sex: M F	Marital Status:

Employer:	Work Phone Number:

Employer Address:	City:	State:	Zip Code:

INSURANCE: MEDICAL INSURANCE:

Insurance Company Name:

Name of Policy Holder:	Date of Birth:	Social Security Number:

Policy Number:	Group Number:

Address of Policy Holder:	City:	State:	Zip Code:

DENTAL INSURANCE:

Insurance Company Name:

Name of Policy Holder:	Date of Birth:	Social Security Number:

Policy Number:	Group Number:

Address of Policy Holder:	City:	State:

OTHER INSURANCE: X MEDICAL X DENTAL

Insurance Company Name:

Name of Policy Holder:	Date of Birth:	Social Security Number:

Policy Number:	Group Number:

FINANCIAL AGREEMENT:

INSURANCE AUTHORIZATION AND AGREEMENT

As a courtesy to our patients, we complete and file insurance forms. It is your responsibility to provide insurance forms, which are completely filled out and signed with benefits assigned to our physician(s). If your insurance company fails to pay your claim, payment is your responsibility regardless whether or not your insurance company deems such procedure(s) medically or dentally necessary.

This office does not determine the benefits under your insurance policy unless requested. If you have specific questions please contact your insurance carrier or employer.

I hereby authorize Dr. Szakaly to furnish information to insurance carriers concerning my treatment and I hereby assign to the physician(s) all payments for services rendered to me or my dependents.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE OF PATIENT OR GUARDIAN DATE

PAYMENT AGREEMENT

I agree to be responsible for my account. In the event that my account becomes delinquent and I default to the terms of this account and my account is referred to a collection agency and/or attorney for collections, I will be responsible for all of their fees which includes attorney's fees of 33 1/3% of the unpaid balance and any court costs expended.

If you cancel with less than 48 hours notice from the time of your appointment, you will be charged a fee of $25 for an office visit and $50 for a surgery.

Your insurance may not deem your intravenous anesthesia or any surgical procedure medically necessary, therefore making the patient/guardian responsible for payment.

SIGNATURE OF PATIENT OR GUARDIAN DATE

Email address: ______________________________

Medical History Form **Dr. Brian Szakaly D.D.S.**

Name: ______________________ Sex M/F Date: ______________

Date of Birth ______________ Age ______ Height ________ Weight ________

General Dentist ______________ Referral Source (if different from dentist) ______________

Occupation ______________________

Reason for visit today/chief dental complaint

____

For the following questions, circle yes or no, whichever applies? Your answers are for our records only and will be kept confidential.

1.	My last physical exam was on _____/_____/_____		
2.	Are you under the care of a physician?	Yes	No
3.	The name of my physician is ______________		
4.	Have you had any serious illness, operation or hospitalization within the past five years.	Yes	No
5.	Have you had an artificial joint replacement (knee, hip, shoulder, etc.)	Yes	No
6.	Do you have a serious congenital heart condition	Yes	No
7.	Do you have a history of infective endocarditis	Yes	No
8.	Are you taking or have you ever taken Bisphosphonates for osteoporosis?	Yes	No
	or chemotherapy for multiple myeloma or other cancers (Fosamax, Actonel Boniva, Aredia, or Zometa?	Yes	No
9.	Do you have or have you had any of the following diseases or problems?	Yes	No
	Damaged heart valves, artificial valves or heart murmur	Yes	No
	Heart attack, angina, high blood pressure. Stroke	Yes	No
	Arteriosclerosis, cholesterol problems or any other heart condition. (please circle all that apply)	Yes	No
a.	Damaged heart valves, artificial valves or heart murmur	Yes	No
b.	Heart trouble, heart attack, angina, high blood pressure, stroke, Arteriosclerosis cholesterol problems or any other heart condition (Please circle all that apply)	Yes	No
	1. Chest Pain upon exertion?	Yes	No
	2. Shortness of breath after mild exercise	Yes	No
c.	Asthma or hay fever	Yes	No
d.	Respiratory problems, emphysema, bronchitis, tuberculosis, etc.	Yes	No
e.	Persistent cough or cough that produces blood	Yes	No
f.	Sleep Apnea	Yes	No
g.	Persistent swollen neck glands	Yes	No
h.	Fainting spells	Yes	No
i.	Epilepsy or neurological disorder	Yes	No
j.	Diabetes	Yes	No
k.	Hepatitis, jaundice or liver disease	Yes	No
l.	Thyroid problems	Yes	No
m.	Arthritis or painful, swollen joints including jaw joint (TMJ)	Yes	No
n.	Osteoporosis	Yes	No
o.	Stomach ulcer or hyperacidity	Yes	No

p. Kidney trouble — Yes No

q. Any disease, drug or transplant operation that has depressed your immune system? — Yes No

10.Have you had abnormal bleeding? — Yes No

a. Have you ever required a blood transfusion? — Yes No

11.Do you have any blood disorder such as anemia (including sickle cell anemia) — Yes No

12. Have you ever had treatment for a tumor/growth (i.e. cancer)? — Yes No

13. Have you had radiation therapy to the head neck or jaws? — Yes No

			Please list which one:
14. Are you taking any of the following medications:	Yes	No	________________
a. Antibiotic or sulfa drug	Yes	No	________________
b. Anticoagulants (blood thinners)	Yes	No	________________
c. Medication for high blood pressure	Yes	No	________________
d. Cortisone (steroids (including prednisone)	Yes	No	________________
e. Tranquilizers	Yes	No	________________
f. Aspirin, ibuprofen (Advil or Motrin)	Yes	No	________________
g. Insulin	Yes	No	________________
h. Digitalis (Drugs for heart failure)	Yes	No	________________
i. Nitroglycerin	Yes	No	________________
j. Antihistamine	Yes	No	________________
k. Other (inc diet pills, herbal, homeopathic or etc..	Yes	No	________________

l. Please list all other medications taking:____

____

15. Are you allergic to any of the following medications or products?

Local Anesthetics	Yes	No	Sulfa Drugs .	Yes	No
Penicillin or antibiotics	Yes	No	Barbiturates or sleeping Pills	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Codeine or other narcotics	Yes	No	Latex or rubber products	Yes	No

Other?____

16. Have you had any serious trouble associated with previous dental treatment? — Yes No

If so explain: ____

17. Do you have any other condition or disease you think the doctor should know about? — Yes No

If so, explain ____

18. Do you have a nervous/psychiatric condition (including depression/anxiety)? — Yes No

If so please explain; ____

19. Do you have a sexually transmitted disease? (Gonorrhea,syphilis,genital warts, HIV, AIDS? — Yes No

20. Do you smoke or chew tobacco? — Yes No

21. Do you drink alcohol beverages? — Yes No

22. are you wearing removable dental appliances? — Yes No

Women:

23. Are you pregnant or trying to become pregnant — Yes No

24. Do you have problems with your menstrual period?Yes/No

25. Are you nursing? — Yes No

26. Are you taking oral contraceptive/hormonal therapy?Yes/No

27. Do you wish to talk with the doctor privately? — Yes No

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.

Patient Signature_______________________________ Physician's Signature ___________________________________