UPSTATE
Oral & Maxillofacial Surgery
& Dental Implant Center

# Medications

| Are you currently taking | Yes | No | Notes |
|---|---|---|---|
| Any medication, drug, pills? | ☐ | ☐ | |
| Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish Oil)? | ☐ | ☐ | |
| Have you ever taken diet pills? | ☐ | ☐ | |
| Natural Products, Herbal Supplements, Homeopathic Remedies? | ☐ | ☐ | |
| Are you taking, or have you taken, bone density meds, RANKL inhibitors or bisphosphonates (Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Evista) in the past 12 years? | ☐ | ☐ | |
| Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list: | | | |
| If under the care of a physician for pain management, or recovering from drug addiction, select the medication you are currently taking: ☐ Methadone ☐ Suboxone ☐ Oxycodone ☐ Fentanyl ☐ Other<br>Treating doctor: | | | |

| Please list any medications you are currently taking: | | |
|---|---|---|
| **Medication** | **Dose** | **Frequency** |
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| Are you allergic/have reaction to: | Yes | No | Notes |
|---|---|---|---|
| Local anesthetic (numbing meds) | ☐ | ☐ | |
| Penicillin | ☐ | ☐ | |
| Other antibiotics | ☐ | ☐ | |
| Sulfa drugs | ☐ | ☐ | |
| Aspirin | ☐ | ☐ | |
| Amoxicillin | ☐ | ☐ | |
| Codeine or other narcotics | ☐ | ☐ | |
| Latex | ☐ | ☐ | |
| Soy | ☐ | ☐ | |
| Eggs/Yolk | ☐ | ☐ | |
| Sulfites | ☐ | ☐ | |
| Sodium pentothal, Valium, other tranquilizers | ☐ | ☐ | |
| Do you have any known allergies? | ☐ | ☐ | |
| Please list any allergies other than drug allergies: | | | |
| Please list any other medication or antibiotic you are allergic to: | | | |
| If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No | | | |
| Who is driving you home? | | | |
| Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Anesthesia Problems | | | |
| Is this visit related to an accident? ☐ Yes ☐ No<br>If Yes, what type of accident?<br>☐ Automobile ☐ Work-related ☐ Other _____<br>Date of injury _____<br>Insurance company handling claim _____<br>Name of attorney/adjustor _____<br>Tel (_____) _____ Claim # _____ | | | |
| Is there any condition concerning your health that the doctor should know about? ☐ Yes ☐ No<br>If Yes, describe: _____<br>Do you wish to speak to the doctor privately about anything? ☐ Yes ☐ No | | | |

I certify that I have read and 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 doctor or any other member of his/her staff responsible for any errors or omissions that I have made in completing this form.

_____ _____ _____ _____
Signature of Patient, Parent, or Guardian | Date | Reviewed by | Date

**Fees & Payments**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

_____ _____
Signature of Patient, Parent, or Guardian | Date

This signature on file authorizes the release of information necessary to process my claim. I hereby authorize payment to this doctor of the benefits otherwise payable to me.

_____ _____
Signature of Patient, Parent, or Guardian | Date

**Authorization**

I authorize my surgeon and his/her designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. Additionally, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment.

_____ _____ _____ _____
Signature of Patient, Parent, or Guardian | Witness | Doctor | Date

**I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.** I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____
Signature of Patient, Parent, or Guardian | Date