

PATIENT MEDICAL HISTORY

1. Are you now or have you been under the care of a physician during the last 5 years? Yes No
 Why? _____

2. Do you take any medicine regularly including over-the-counter and prescription drugs? Yes No
 If yes, what? _____

3. Do you have a bleeding problem? Yes No Do you take anticoagulants (blood thinners) such as aspirin or Coumadin? Please list: _____

4. Have you ever taken a medication such as Fosamax, Zometa, Actonel, Boniva, Didronel, Skelid, Aredia, Reclast, Bonafos, Prolia, Xgeva, Sutent (Sunitinib) to increase bone density? Other _____

5. Were you ever hospitalized for a major illness and/or operation? Yes No
 What? _____
 When? _____
 Where? _____

6. Have you ever had a general anesthetic? _____ If yes, any difficulties? _____

7. Patient's Height _____ Weight _____ Age _____

8. Are you now or have you ever been treated for any of the following? Please check yes or no on each line.

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9. Have you ever used or do you currently use Suboxone or any illegal drugs such as steroids, cocaine, heroin or marijuana? Yes No

11. Are you sensitive or allergic to latex or any drug such as penicillin, aspirin, novocaine, codeine or other? Yes No _____

12. Have you ever had difficulties with dental treatment or local anesthesia? Yes No
 If yes, please explain _____

13. Reason for today's visit: (please explain)

Date _____ Signed _____

PATIENT INFORMATION (PLEASE PRINT)

(Mr., Mrs., Ms.) _____ Patient Name _____ Sex: M F
Mailing Address _____ City _____ State _____ Zip _____
Phone Numbers Home _____ Business _____ Cell _____
Date of Birth _____ Age _____ Social Security # _____
Dentist _____ Orthodontist _____ Physician _____ Referred By _____
Occupation _____ Place of Employment _____
Spouse _____ Social Security # _____
Address _____ Employer _____
Emergency Contact Name and Phone _____

INSURANCE INFORMATION

Medical Insurance _____ Dental Insurance _____
Subscriber Name _____ Subscriber Name _____
SS# _____ SS# _____
Date of Birth _____ Date of Birth _____

PARENT/GUARDIAN INFORMATION

Mother _____ Father _____ Other _____
Name _____ HomePhone _____ WorkPhone _____
Address _____ Birth Date _____
Employer _____ Social Security # _____

COLLEGE STUDENT

Name of School _____ Address _____
Graduation Date _____ Part Time _____ Full Time _____

We make every effort to keep down the cost of your oral surgical care. Payment is expected upon completion of each visit. If you have an insurance that our office is not participating with, after payment in full for services, a coded statement will be given to you so you can bill your insurance directly for your reimbursement.

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. **General anesthesia is not always a covered benefit. It is your responsibility to pay any deductible, co-insurance, charges for non-covered procedures (in some instances general anesthesia) or any other balance not paid for by your insurance company. A fee will be charged to your account for any returned checks.**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment of insurance benefits to this treating doctor, that otherwise would have been payable to me.

Signature _____ Date _____

CALLAHAN AND BERGEY ASSOCIATES, P.C.

**ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I can request a copy of this office's Notice of Privacy Practices and that the Notice of Privacy Practices is accessible in the waiting room.

E-MAILING X-RAYS TO YOUR DENTIST

X-rays emailed from this office to your Doctor/Dentist will NOT be encrypted. Your name is the only other personal information that is attached to your x-ray. Callahan and Bergey Associates cannot guarantee, but will use reasonable means to maintain the security and confidentiality of email sent and received. We take appropriate precautions when transmitting email to avoid unintentional disclosures, such as verifying email address for accuracy before sending. The Practice is not liable, however, for improper disclosure of confidential information that is not caused by our unintentional misconduct. Prior to giving your consent, it is important for you to be aware of the inherent risks of sending and receiving confidential information by e-mail, (i.e., email messages can be intercepted, circulated, altered, forwarded, stored or used without authorization or detection)

_____ **YES** email x-rays

_____ **DO NOT** email x-rays

FAMILY MEMBER WE CAN RELEASE INFO TO

Name _____ Relationship _____

Name _____ Relationship _____

PATIENT or Guardian Signature

Print Name

Relationship to Patient

Date