YEN ORAL SURGERY

Welcome to our office! Please fill out the following information:

Name _____ Birth Date ___/___/___ Sex ___ Contact # _____

Address _____ City _____ State ____ Zip_____

Occupation _____ Employer _____ School _____

Person responsible for account (if different from above)

Name _____ Relationship _____ Contact # _____

Referring Dentist _____ Purpose of visit _____

Insurance Information

Primary Insurance Information

Name _____ SS or ID Number _____ Birth Date _____/_____/_____

Insurance Company Name _____ Group Number _____

Secondary Insurance Information

Name _____ SS or ID Number _____ Birth Date _____/_____/_____

Insurance Company Name _____ Group Number _____

Acknowledgement and Authorization

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to Special Consultation, whatever drugs, medicine, performance of operations and conduct of laboratory, x-rays, or other studies that may be used by the attending doctor, or his qualified designate.

I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, **at the time of service**, unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a service charge of 1.5% per month (18% annual percentage rate) and I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account. I understand that where appropriate, a credit check may be made through a credit bureau.

Signature _____ Date _____ Relationship to patient _____

Insurance Release

Authorization to pay and release information: I hereby authorize insurance benefit payments directly to Kirk Yen, DDS, or Kevin Yen, DDS MD, for his services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original. I also authorize Kirk Yen, DDS, or Kevin Yen, DDS MD, to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

Signature _____ Date _____ Relationship to patient _____

Patient Health History

Currently under the care of a physician? **Y N** Name of physician? _____ Date of last exam: _____

Any illnesses, operations, or hospitalizations in the past 5 years? **Y N** Explain: _____

Unhealed/recurrent, or inflamed areas, growths, or sores in/around your mouth? **Y N** Prosthetic joint/implant? **Y N** Heart valve replacement? **Y N**

Have you ever had general anesthesia? **Y N** Have you or a family member ever had any reaction to general anesthesia? **Y N**

Has a physician or previous dentist recommend antibiotics prior to dental treatment? **Y N**

Ever taken any bone density medications, bisphosphonates (Fosamax, Boniva, Actonel, Zometa, etc.), or RANKL inhibitors by mouth or by IV? **Y N**

HAVE YOU EVER HAD OR DO YOU HAVE?

Y N Diabetes	**Y N** Excessive Bleeding	**Y N** Chronic Sinusitis	**Y N** STD
Y N High Blood Pressure	**Y N** Thyroid Disorder	**Y N** Kidney Disease	**Y N** HIV
Y N High Cholesterol	**Y N** Tuberculosis	**Y N** Liver Disease	**Y N** Sleep Apnea
Y N Asthma	**Y N** Alcoholism	**Y N** Lung Disease	**Y N** Allergies
Y N Heart Problems	**Y N** Drug Use	**Y N** Cancer	To what:_____
Y N Fainting or Dizzy Spells	**Y N** Ulcers	**Y N** Chemotherapy	_____
Y N Seizures	**Y N** Glaucoma	**Y N** Radiation Therapy	**Y N** Family history of disease
Y N Arthritis	**Y N** Pregnant	**Y N** Clicking Jaw Joints	Explain:_____
Y N Anemia	**Y N** Psychiatric Treatment	**Y N** Tobacco Use	_____

Any other medical conditions not listed above: _____

Please list any medications: _____