BRUCE H. McCULLAR, DDS

Today's Date:	**Referring Dentist:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Race:

Nickname:	EMAIL ADDRESS:	Birth date:	Age:	Sex: M F

Address **CITY** **STATE** **ZIP**

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

PLEASE CHECK IF YOU NEED AN EXCUSE FOR _____WORK ____SCHOOL

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Cell phone no.:

PLEASE PROVIDE GUARANTOR'S INFORMATION IF DIFFERENT THAN PATIENT

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

PLEASE FILL OUT COMPLETELY AND PROVIDE INS CARDS TO BE COPIED

PRIMARY DENTAL INSURANCE NAME AND ADDRESS			**SECONDARY DENTAL INSURANE NAME AND ADDRESS**		
INSURANCE TELEPHONE NUMBER:			INSURANCE TELEPHONE NUMBER:		
SUBSCRIBER NAME:		DOB:	SUBSCRIBER NAME:		DOB:
SS NO.:	MEMBER ID:	GROUP NO.:	SS NO.:	MEMBER ID:	GROUP NO.:
RELATIONSHIP TO PATIENT:			RELATIONSHIP TO PATIENT:		

PRIMARY MEDICAL INSURANCE NAME AND ADDRESS			**SECONDARY MEDICAL INSURANCE NAME AND ADDRESS**		
INSURANCE TELEPHONE NUMBER:			INSURANCE TELEPHONE NUMBER:		
SUBSCRIBER NAME:		DOB:	SUBSCRIBER NAME:		DOB:
SS NO.:	MEMBER ID:	GROUP NO.:	SS NO.:	MEMBER ID:	GROUP NO.:
RELATIONSHIP TO PATIENT:			RELATIONSHIP TO PATIENT:		

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

Patient's Name: **Reason for today's office visit:**

1. Height_____Weight_____ Are you in good health?.....YES ___ NO ___
2. Have there been any changes in your general health in the past year?.....YES ___ NO ___
3. Are you under the care of a physician?.....Date of last visit_____ YES ___ NO ___

   If so, for what are you being treated? _____

   Name of Physician and Telephone No.:_____
4. Have you had any illness, operation or been hospitalized in the past five years?.....YES ___ NO ___

   If so, describe_____
5. Do you have unhealed/recurrent injuries or inflamed areas, growths or spots in or around your mouth?.....YES ___ NO ___
6. Do you have a prosthetic joint/implant?.....If so, describe where _____ YES ___ NO ___
7. Have you had a heart valve replacement or vesicular graft?.....YES ___ NO ___
8. Have you ever had general anesthesia?.....YES ___ NO ___
9. Have you, or a family member, had any unusual or serious reactions to general anesthesia?.....YES ___ NO ___
10. Do you have a medical condition, heart or prosthetic joint, that requires you to take antibiotics prior to dental appointment?

    .....YES ___ NO ___
11. **Ladies – Are you pregnant? _____Yes _____No ____ I don't know**

HAVE YOU HAD OR DO YOU CURRENTLY HAVE:

	YES	NO		YES	NO
Rheumatic Fever			Damaged heart valves/mitral valve prolapse		
Heart murmur			Emphysema		
High Blood Pressure			Do you smoke		
Low Blood Pressure			Do you use chewing tobacco		
Chest pain/angina			Blood transfusion		
Heart Attack(s)			Blood disorder such as anemia		
Irregular heart beat			Bruise easily		
Cardiac pacemaker			Bleeding tendency/abnormal bleeding		
Heart surgery			Hepatitis, jaundice, or liver disease		
Pneumonia, bronchitis, chronic cough			Gallbladder trouble		
Asthma			Fainting spells		
Hay fever/sinus problems			Convulsions/epilepsy		
Snoring			Stroke		
Sleep Apnea/CPAP			Thyroid trouble		
Difficult breathing/other lung trouble			Diabetes		
Tuberculosis			Low blood sugar		
Kidney trouble			Sexually transmitted diseases		
High cholesterol			Problems with immune system		
Are you on dialysis			Delay in healing		
Swollen ankles/arthritis/joint disease			A tumor or growth		
Osteoporosis/osteopenia			Cancer/radiation therapy/chemotherapy		
Acid reflux			Chronic fatigue/night sweats		
Stomach/GI troubles/ulcers/IBS/Colitis			Are you on a diet		
Contagious diseases			A history of alcohol abuse		
A history of drug abuse			A removal dental appliance		
Contact lenses			Pain or clicking in jaws when eating		
Eye disease/glaucoma			Mental health problems/anxiety/depression		

LIST ANY MEDICATIONS YOU ARE TAKING:

ARE YOU TAKING OR HAVE YOU EVER TAKEN BONE DENSITY MEDS, OR BISPHOSPHONATES, SUCH AS FOSAMAX, BONIVA, ACTONEL IV -ZOMETA, ARDIA, XGEVA, PROLIA, OR RECLAST IN THE PAST 12 YEARS. ___YES ___NO

Are you allergic to, or had a reaction to and medication, anesthetic, or foods? Please list in the space below.

If you are having surgery TODAY, have you had anything to eat or drink in the last 8(eight) hours? ___YES ___NO

If you are going to sleep for surgery today, your driver and car must stay. Who is your driver? _____

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

X _____ _____

Signature of patient/ Guardian **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. Please remember that insurance is considered a method of reimbursing the patient for fees 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.** Any balance remaining after insurance has paid, will be considered past due 30 days following. You will be responsible for all collection costs, attorney's fees, and court costs in the event your account is placed with a collection agency.

I authorize my insurance benefits to be paid directly to Bruce H. McCullar, DDS. I understand that I am financially responsible for any balance. I also authorize BRUCE H. McCULLAR, DDS or insurance company to release any information required to process my claims.

X

Signature of Patient/Guardian **Date**

AUTHORIZATON

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, to diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired during 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.

X_____ _____

Signature of Patient /Guardian **Date**

BRUCE H. McCULLAR, DDS

CONSENT FOR USES AND DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name: _____

Address: _____

Home Phone: _____Cell Phone: _____

Please check your preferred means of communication:

__You may contact me at my home telephone number _____
__You may call and leave message on my cell phone number _____
__You may contact me on my work phone number _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) with:

1: _____Phone: _____
2: _____Phone: _____

PRIVACY POLICY:

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you. We need this record to provide for your care and to comply with certain legal requirements. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy before signing this consent. The terms of our Notice may change. You may obtain a copy of the Notice by contacting our office.

Medical Information

I authorize Bruce H. McCullar, DDS permission to release or obtain any of my records to or from any physician, pharmacy, healthcare facility, insurance company, self-insurer or their representative that has assisted in my case.

I have had full opportunity to read the Notice of Privacy Practices of Bruce H. McCullar, DDS, P.C. I hereby authorize, as indicated in my signature below, Dr. McCullar to use and disclose my protected health information for any necessary clinical, financial and insurance purpose.

_____Date: _____
Signature of Patient or Legal Guardian

Please print name: _____