



WELCOME TO THE DOWNRIVER SURGERY CENTER

Have you ever been a patient of our practice? Yes No Method of Personal Payment: Cash Check Credit Card

Date: _____

Patient: (Mr., Mrs., Ms., Dr.) First Name _____ M.I. _____ Last Name _____ Nickname _____
 Sex: Male Female Date of Birth _____ Age _____ Social Security # _____
 Street _____ City _____ State _____ Zip _____
 Home Tel.# (____) _____ E-mail Address _____ Cell Phone _____
 Business Tel. # (____) _____ Ext. _____ Employer _____
 Dentist _____ Ph. # _____ Medical Doctor _____ Ph. # _____ Referred by _____ Ph. # _____
 Driver's Lic. # _____ Nearest relative not living with you _____ Tel. #(____) _____

Who will be responsible for your account? Self Spouse Father Mother Other _____
(If self, skip to next paragraph)
 Name _____ Soc. Sec. _____ Birth Date _____ Home Tel.: (____) _____
 Street _____ City _____ State _____ Zip _____
 Employer _____ Tel.: (____) _____

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD? Yes No
 Is there a **family history** of: **Cancer** Yes No **Diabetes** Yes No **Heart Disease** Yes No **Anesthetic Problems** Yes No
IN CASE OF EMERGENCY, CONTACT: Name _____ Tel # H: (____) _____ Wk: (____) _____

IS THIS VISIT RELATED TO AN ACCIDENT? Auto: Yes No Work Related: Yes No Other: Yes No
 Date of Injury: _____ Insurance Co. handling this claim: _____ Claim #: _____
 Name of Attorney / Adjustor _____ Tel #: (____) _____

PRIMARY DENTAL INSURANCE COMPANY

Employer _____
Ins. Co. Name _____
 Address _____
 _____ Phone: (____) _____
Group #: _____
 Policyholder _____ Relation _____
 Sex: M F
 Date of Birth: _____
 I.D. #: _____ S.S.#: _____

PRIMARY MEDICAL INSURANCE COMPANY

Employer _____
Ins. Co. Name _____
 Address _____
 _____ Phone: (____) _____
Group #: _____
 Policyholder _____ Relation _____
 Sex: M F
 Date of Birth: _____
 I.D. #: _____ S.S.#: _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____
Ins. Co. Name _____
 Address _____
 _____ Phone: (____) _____
Group #: _____
 Policyholder _____ Relation _____
 Sex: M F
 Date of Birth: _____
 I.D. #: _____ S.S.#: _____

SECONDARY MEDICAL INSURANCE COMPANY

Employer _____
Ins. Co. Name _____
 Address _____
 _____ Phone: (____) _____
Group #: _____
 Policyholder _____ Relation _____
 Sex: M F
 Date of Birth: _____
 I.D. #: _____ S.S.#: _____

HEALTH HISTORY

TO OUR PATIENTS: 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.

Reason for today's office visit: _____

Yes No

- A.**
1. Are you in good health? Height _____ Weight _____
 2. Have there been any changes in your general health in the past year? _____
 3. Are you under the care of a physician?.....Date of last visit: _____
If so, for what are you being treated? _____
 4. Have you had any serious illness, operations or hospitalizations? If so, describe.....

 5. Do you have a prosthetic joint/implant?If so, described where _____
 6. Have you had a heart valve replacement or vascular graft?.....

B.	HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE....	Yes	No	NOTES	
1	Rheumatic fever?				27	Stroke?			
2	Damaged heart valves ? mitral valve prolapse?				28	Thyroid trouble?			
3	Heart murmur?				29	Diabetes?			
4	High Blood Pressure?				30	Low blood sugar?			
5	Low Blood Pressure?				31	Kidney trouble?			
6	Chest Pain, angina				32	Are you on dialysis?			
7	Heart attack(s)?				33	Swollen ankles, arthritis or joint disease?			
8	Irregular heart beat?				34	Stomach ulcers?			
9	Cardiac pacemaker?				35	Contagious diseases?			
10	Heart surgery?				36	Sexually transmitted diseases?			
11	Bronchitis, chronic cough?				37	Problems with the immune system?			
12	Asthma?				38	Delay in healing?			
13	Hay fever / Sinus problems?				39	A tumor or growth?			
14	Tuberculosis?				40	X-Ray treatment / chemotherapy?			
15	Emphysema?				41	Chronic fatigue / night sweats?			
16	Difficult breathing / other lung trouble				42	Are you on a diet?			
17	Do you smoke?				43	A history of drug abuse?			
18	Blood transfusion?				44	A history of alcohol abuse?			
19	Blood disorder such as anemia?				45	Contact lenses?			
20	Bruise easily?				46	Eye disease / glaucoma?			
21	Bleeding tendency (abnormal bleed?)				47	Mental health problems?			
22	Jaundice, hepatitis or liver disease?				48	A removable dental appliance?			
23	Infectious Mononucleosis?				49	Pain & Clicking of jaws when eating?			
24	Gallbladder trouble?				50	Malignant Hyperthermia?			
25	Fainting spells?				51	Have you had anything to eat or			
26	Convulsions, epilepsy?				52	Who is driving you home today?			

C. MEDICATION

ARE YOU NOW TAKING...	Yes	No	Notes	ARE YOU NOW TAKING...	Yes	No	Notes
1. Any kind of medicine, drugs, or pills?				4. Tranquilizers?			
2. Anticoagulants?				5. Cortisone?			
3. Diet Pills?				6. Other medications (please list)?			

D. ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Ye	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO...	Ye	No	Notes
7. Local anesthetics?				12. Codeine or other narcotics?			
8. Penicillin?				13. Other medications?			
9. Other antibiotics?				14. Allergies other than drug allergies			
10. Sodium pentothal, valium, or other tranquilizers?				(please list)			
11. Aspirin?							

E. WOMEN

15. Is there a possibility of pregnancy?				17. Are you nursing?			
16. Estimated delivery date ___/___/___				18. Are you taking birth control pills?			

WOMEN NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

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

Initials:

FEES & PAYMENTS

We make every effort to keep down the cost of your surgical 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, attorneys fees, and court costs. In order to assure a response from your insurance company within the allowed time of 30 days, any claim that is not responded to within 30 days is subject to a complaint against the insurance company. Your signature authorization will permit us to write to the insurance commissioner, which will expedite your reimbursement.

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

Initials:

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an 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. In addition, if medically necessary, I authorize the release of any information acquired

Initials:

Date

Signature of Patient
(Parent or Guardian if minor)

Witness:

Doctor: