ALABAMA ORAL & FACIAL SURGERY

www.alabamaoralsurgery.com

HENRY E. MCKAY, III DDS **CHRISTOPHER M. ROTHMAN, DDS** **WILL SMALLEY, DMD**

PATIENT INFORMATION____**DATE**_________________

Name: ____ Preferred First Name: __________________

Patients Address: ____City:________________________State: ____Zip:____________

Date of Birth ____/______/_______Home#: (____)_______________Cell #: (____)________________ Work#:(___)________________

SS#______/_____/_______ SEX:_ M or F_ Marital Status: _M S D W_ Email Address: ______________________________________

Employer Name & Address: ___________________________________ City: _______________________ State: ____Zip: _____________

REFERRING INFORMATION____

Referring Dentist: _________________ Internet: _____Friend: _____Insurance Website:_________ Other: ________________________

INSURANCE INFORMATION____

Dental Insurance: _________________________________ Policy Holders Name: ____
Policy Holder's SS#: _________/________/________ DOB: _______/________/________ Employer: ______________________________
Member ID/Contract#: _______________________________ Plan/Group#: ___________

Secondary Dental: _________________________________Policy Holders Name: ____
Policy Holder's SS# __________/_________/_________ DOB: _______/________/_______ Employer: _____________________________
Member ID/Contract#: _______________________________Plan/ Group#: ____________

Medical Insurance: ________________________________ Policy Holders Name: ____
Policy Holder's SS#: __________/_________/__________ DOB: ______/_______/______Employer: _______________________________
Member ID/Contract#: _________________________________Plan/Group#: ___________

Secondary Medical: ________________________________Policy Holders Name: ____
Policy Holder's SS#: _________/_________/__________DOB: _______/_______/_______Employer: _______________________________
Member ID/Contract#: _________________________________Plan/Group#: ___________

EMERGENCY CONTACT INFORMATION____

Name: ________________________________Email address: ____________________________________
Address: ____
Relationship to patient: __________________Home#:_____________________Cell#:___________________ _________
Medical information can be discussed with: _________________________relationship:________________ _______

DRIVER'S INFORMATION/PERSON RESPONSIBLE DRIVING YOU HOME FROM SURGERY_____________

Driver's name_____________________/Relation______________/Cell #_____________DOB:___/___/___

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS OR DISCUSS ANY MEDICAL INFORMATION TO:

____

AUTHORIZATION INFORMATION____

I authorize the Doctor/Staff to perform oral surgery and or examination for the purpose of treatment. I also, authorize the taking of x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment. Furthermore, 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 or legal guardian X____

PATIENT NAME____**DATE** ____________________

ARE YOU IN A PAIN MANAGEMENT PROGRAM: Yes: ___No: ___ **ARE YOU PREGNANT**: Yes:____ No:_____

List any drug allergies: ____
Food allergies: ____

Latex Allergy: Yes____ No_____ **Egg allergy:** Yes____ No ______ **Tobacco User**: Yes_____ No_______

Are you taking any bone building medications such as **FOSAMAX, BONIVA, ACTONEL**,ETC? LIST___________________
Are you taking any blood thinners such as **COUMADIN, PLAVIX, ASPIRIN,** ETC?LIST ______________________________

Have you ever had radiation treatment for cancer to the head or neck? Yes ______No _______
If yes, please list treating doctor's name and phone#: ____

PLEASE PROVIDE US WITH YOUR **PHARMACY NAME & NUMBER**: ____

MEDICAL HISTORY/PLEASE CHECK IF ANY APPLY TO YOU____

____ALZHEIMER
____ASTHMA
____BLEEDING PROBLEMS
____CANCER, TUMOR /TYPE________
____COLITIS
____DIABETES
____EMPHYSEMA
____EPILEPSY/SEIZURE DISORDER
____FAINTING SPELLS
____HEART ATTACK
____HEART DISEASE
____HEART MURMUR
____HEPATITIS ____A____B____C
____HIV POSITIVE
____HIGH BLOOD PRESSURE
____LOW BLOOD PRESSURE
____LIVER DISEASE

____MITRAL VALVE PROLAPSE
____NERVOUS DISORDER
____PROSTHETIC HEART VALVE
____PROSTHETIC (ARTIFICIAL)JOINT REPLACEMENT
____RHEUMATIC FEVER
____SLEEP APNEA
____STEROID THERAPY
____STROKE
____THYROID DISORDERS
____TUBERCULOSIS
____OTHER___________________________________

Please list current medications:___________________
____
____
____
____

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE QUESTIONS ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE INQUIREIS 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. **PATIENTS/OR LEGAL GUARDIAN SIGNATURE____DATE:__________________**

ARE YOU RECEIVING GENERAL ANESTHESIA TODAY? YES _____NO_____
IF YES, HAVE YOU HAD ANYTHING TO EAT OR DRINK IN THE LAST SIX HOURS? YES _____NO _____
HAVE YOU HAD SURGERY IN THE LAST 6 MONTHS THAT REQUIRED GENERAL ANESTHESIA? YES ____NO____
PLEASE LIST ANY AND ALL SURGERIES: ____
PATIENTS RECEIVING GENERAL ANESTHESIA MAY NOT BE DROPPED OFF AND DRIVERS AND THE VEHICLES MUST REMAIN AT THE OFFICE AT ALL TIMES.