M·SHANE STEVENSON·DMD·MD
ORAL MAXILLOFACIAL SURGERY

NEW PATIENT FORM

PATIENT INFORMATION

Name ______________________ Birthdate ______________________

Cell Phone ______________________ Email ______________________ Home Phone ______________________

Address ______________________

Social Security No. ______________________ Marital Status ______________________

Patient's or Parent's Employer ______________________ Work Phone ______________________

Business Address ______________________

Spouse of Parent's Name ______________________ Employer ______________________ Work Phone ______________________

If Patient is a Student, Name of School/College ______________________ City ______________________ State ______________________

Whom May We Thank for Referring You? ______________________

Dentist ______________________ Physician ______________________

Person to Contact in Case of Emergency ______________________ Phone ______________________

RESPONSIBLE PARTY

Name of Person Responsible for the Account ______________________ Relation to Patient ______________________

Address ______________________ Home Phone ______________________

Driver's License # ______________________ Birthdate ______________________

Employer ______________________ Work Phone ______________________

Currently a Patient in our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured ______________________ Relation to Patient ______________________

Birthdate ______________________ Social Security # ______________________

Employer ______________________ Work Phone ______________________

Employer Address ______________________

Insurance Company ______________________ Contract # ______________________ Group # ______________________

Address ______________________

ADDITIONAL INFORMATION

Name of Insured ______________________ Relation to Patient ______________________

Birthdate ______________________ Social Security # ______________________

Employer ______________________ Work Phone ______________________

Employer Address ______________________

Insurance Company ______________________ Contract # ______________________ Group # ______________________

Address ______________________

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Parent if Minor ______________________ Date ______________________

Payment is due in full at time of treatment unless prior arrangements have been approved.

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CORE MEDICAL HISTORY

Have you had surgery in the past? ❑ Yes ❑ No

Have you been hospitalized? ❑ Yes ❑ No

Are you now or have you been under the care of a physician in the past 5 years? ❑ Yes ❑ No

Do you take any medicine regularly? ❑ Yes ❑ No

Are you subject to fainting, dizziness, nervous conditions, convulsions or epilepsy? ❑ Yes ❑ No

Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis or any lung disorder? ❑ Yes ❑ No

Have you ever had any of the following illnesses?
❑ Heart Trouble
❑ Kidney Disease
❑ Stroke
❑ High or Low Blood Pressure
❑ Rheumatic Fever
❑ Diabetes
❑ Hepatitis or Liver Trouble
❑ Anemia

Are you subject to profuse bleeding? ❑ Yes ❑ No

Are you sensitive or allergic to any drugs such as penicillin, aspirin, Novocain or codeine? ❑ Yes ❑ No

Do you have a cold, cough or sinus trouble? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Pregnancies (Females) ❑ Present ❑ Past

Do you smoke? ❑ Yes ❑ No

Do you frequently use alcohol or any drugs that may affect our use of anesthesia? ❑ Yes ❑ No

Do you have any reason to believe you might be immunosuppressed? (chemotherapy, transplant surgery, HIV) ❑ Yes ❑ No

Have you experienced chronic fatigue, night sweats, chronic cough or recurrent mouth sores? ❑ Yes ❑ No

Have you had previous facial injuries or fractures? ❑ Yes ❑ No

Do you take any diet or herbal medication? ❑ Yes ❑ No

Do you have any TMJ problems? ❑ Yes ❑ No

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