M / F

Patient's Name Today's Date Gender Age

Person completing form if other than patient and relation:_____

HEALTH HISTORY *Oral Surgery of Springfield*

Please use the reverse side if more space is needed and circle words below that describe your conditions

Answer all questions by circling Yes (Y) or No (N). All responses are kept confidential in accordance with HIPPA .

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

   _____
6. **Height _____ Weight _____**
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease?.....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis? or Fibromyalgia .....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
   - O. Radiation (X-ray) treatment for Cancer?.....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? .....Y N
   - S. Have you ever taken Bisphosphonate drugs such as Aredia, Zometa, Fosamax or Actonel, for osteoporosis or chemotherapy as for multiple myeloma?. . . .. . .Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (i.e.Coumadin) (Blood Thinners)?...Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications?.....Y N
   - E. Steroids (Cortisone, prednisone etc.)?.....Y N
   - F. Any steroids in the last two years?.....Y N
   - G. Any tranquilizers or Antidepressants?.....Y N
   - H. Insulin or Oral Diabetic drugs?.....Y N
   - I. Digitalis, Inderal, Nitroglycerin or heart drugs? Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin, amoxicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products?.....Y N
   - G. Other allergies or reactions? Please, list.....Y N

     _____
10. Have you ever smoked tobacco products.....Y N
    If so how many years did you smoke:_____
    If you quit then when did you quit: _____
    If you still smoke then how much per day now? _____
11. Have you ever used smokeless tobacco or chew…….Y N
    If so how many years:_____
    If you quit then when did you quit?_____
12. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
13. Have you had any serious problems associated with any previous dental treatment?.....Y N
14. Have you or an immediate family member had any problem with intravenous or general anesthesia?.....Y N
15. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
16. Do you wish to talk to the doctor privately about anything? .....Y N
17. **FOR WOMEN ONLY**
    - A. Pregnant or **<u>any chance</u>** you might be Pregnant?...Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) interfere with the effectiveness of oral contraceptives. You will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or medication is completed. Please consult with your physician for further guidance. Do you understand? Y N

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible.

_____ _____

Date Signature of Patient/ Guardian

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ASSIGNMENT OF BENEFITS

I consent to medical/dental examination, laboratory procedures, and other studies ordered by physicians, advanced practice nurses, physician assistants or other health care providers of Frank A. Cornella, D.D.S., M.D., P.C.

I authorize Frank A. Cornella, D.D.S., M.D., P.C. to disclose to the Social Security Administration or its intermediaries or carriers, and/or my insurance company, any information relating to the identity, diagnosis, programs, or treatment of the patient. This may be done electronically if available. I understand the purpose of this disclosure is to facilitate the payment of insurance benefits. This is a direct assignment of my rights and benefits under this policy.

I request payment of insurance benefits to be made to Frank A. Cornella, D.D.S., M.D., P.C. and authorize any holder of medical information including, but not limited to insurance companies, adjusters, and attorneys to release this information to my insurance company as well as any information needed to determine benefits payable for services.

In consideration for services rendered, I hereby assign to Frank A. Cornella, D.D.S., M.D., P.C. benefits to which I am entitled under the terms of my insurance policy(ies), **and agree to be responsible for services not paid in whole or in part by my insurance company,** which I hereby certify is in full force and effect. This authorization will remain in force and effect until revoked by me in writing. I have read all the information on this sheet and verify the information I am giving is true and correct to the best of my knowledge. I will notify this office of any changes of this information.

Any charges deemed medically or dentally unnecessary by your insurance company become your responsibility.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Frank A. Cornella, D.D.S., M.D., P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf when there are unreasonable delays in receiving payment from my insurance provider.

NOTE: If you are found to have a condition, such as cancer, which must be reported to a county, state or national health agency your diagnosis will be reported as required by law to the appropriate agency.

SIGNATURE:_____ DATE: _____

Financial Agreement

We accept a wide variety of Insurances and are Preferred Providers for many. Payment is due at the time of service. A payment is required at the time of scheduling procedures. **When Insurance is to be filed, a 20% patient portion is required at time of scheduling, unless a predetermination is requested. Upon your request we will submit an inquiry to your insurance for a predetermination of your insurance coverage. However, this still is only an ESTIMATE. Since your insurance policy is a contract between you and the insurance company, we CANNOT guarantee the accuracy of information.**

Although we will assist in filing our insurance claim, payment to us is **solely your responsibility**. If insurance does not pay in full in a timely manner, we will require you to pay any balance due.

When there is no insurance involved, a payment of 50% of the estimated fee will be due at the time of scheduling and then the remainder is due at time of service. But if services are rendered in one visit, it would be due at that time.

In order to maintain respect for other patient's needs for the doctor's time, a fee of $30 will be charged for appointments that are not cancelled with at least 24 hours notice. Exceptions will be made with a doctor's excuse. This fee is due before the appointment can be rescheduled. Missed appointment increase the cost of health care for everyone.

To avoid potential ethical and legal issues, and to help keep the cost of care as low as possible for all our patients, this office does not extend professional courtesy.

Delinquent accounts will be sent to collections. Signing this also constitutes a release of any information and documentation needed for collection purposes. **Returned checks will be subject to a $30 fee.**

Signature:_____ Date:_____