KATY CYPRESS
ORAL SURGERY & IMPLANT CENTER

Patient Information

Date:_____

Patient's Name_____Preferred Name _____
Last First Middle

Address_____Birth Date_____

City_____State_____Zip Code_____Social Security #_____

Home Phone #_____Cell #_____Work #_____

Email Address_____

Authorize to receive texting communications regarding appointments? Yes or No

Authorize to receive email communications from Katy Cypress Oral Surgery? Yes or No

Gender: Male Female

Marital Status: Married Single Divorced Separated Widowed

Dental Office that Referred You_____

Doctor that Referred You_____

If not referred by Doctor, who may we thank for referring you to our office?_____

Responsible Party Information (if someone other than patient)

Patient's Name_____
Last First Middle

Address_____Birth Date_____

City_____State_____Zip Code_____Social Security #_____

Home Phone #_____Cell #_____Work #_____

Email Address_____Relationship to Patient_____

Payment in full is due at the time of your scheduled appointment unless arrangements have been made and approved prior to the appointment.

We ask that you please notify us by phone at least 48 hours in advance if needing to reschedule or cancel any appointments. Failure to comply will result in a $50 charge being assessed to your account.

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Patient's Name_____ Date of Birth____/_____/_____

Gender: Male/ Female Height_____Weight_____

Health History Form

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Date of last physical exam ____/_____/_____ Name of Primary Care Physician _____

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why? _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: _____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship _____	Cancer?	Yes	No	Relationship _____
Heart disease?	Yes	No	Relationship _____	Bleeding problems?	Yes	No	Relationship _____
Tumors?	Yes	No	Relationship _____	Lung disease?	Yes	No	Relationship _____

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

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Patient's Name_____ Date of Birth____/_____/_____

Gender: Male/ Female Height_____Weight_____

MEDICATIONS

Please list your medications you have taken or are currently taking including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals:

_____

_____

_____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? _____

Have you ever sought professional care or been hospitalized for:			**Do you use:**			
Drug abuse?	Yes	No	Alcohol?	Yes	No	How often? _____
Emotional disorders?	Yes	No	Marijuana?	Yes	No	How often? _____
Alcoholism?	Yes	No	Recreational drugs?	Yes	No	How often? _____

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?_____

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible.
To the best of my knowledge, the above information is complete and correct.

_____ _____

Signature of patient, parent, guardian Date

_____ _____

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review the secure copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions of how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date_____

Print Patient Name_____

Relationship to Patient_____

People we can disclose to_____

Signature_____