Modesto Oral Surgery
Implants, Facial And Oral Surgery

Brian K. Hutto, DMD, MS.Ed 209-522-5238

Welcome to our Practice

Today's Date_____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. #_____ E-mail _____

Street_____ Apt. _____ City _____ State _____ Zip_____

Home Tel. (_____) _____Cell. (_____)_____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ Has a family member ever been a patient of our practice? ❑ Yes ❑ No
FIRST NAME LAST NAME

Dentist _____ Orthodontist _____ Medical Dr. _____
FIRST NAME LAST NAME FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's Lic. #_____Nearest relative not living with you _____ Tel. (____)_____
FIRST NAME LAST NAME

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____)_____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ S.S. # _____ Birth Date _____ Age _____

Tel. (_____) _____ Cell. (_____)_____ E-mail _____

Street_____ Apt. _____ City _____ State _____ Zip_____

Driver's Lic. #_____ Employer _____ Bus. Tel. (____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name _____ Relation _____ S.S. #_____ Birth Date _____
FIRST NAME LAST NAME

Street_____ Apt. _____ City _____ State _____ Zip_____

Tel. (_____)_____ Employer _____ Bus. Tel. (____)_____

INSURANCE INFORMATION:

Student: ❑ Full Time ❑ Part Time ❑ Not

Marital Status: ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____
ADDRESS CITY STATE ZIP

Bus. Tel. (____) _____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____
ADDRESS CITY STATE ZIP

Tel. (____) _____ Group Name _____

Group # _____ Insured Party _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (_____) _____

Address _____
ADDRESS CITY STATE ZIP

SECONDARY INSURANCE COMPANY:

Employer _____

Bus. Address _____
ADDRESS CITY STATE ZIP

Bus. Tel. (____) _____ Plan _____

Ins. Co. Name _____ I.D. #_____

Address _____
ADDRESS CITY STATE ZIP

Tel. (____) _____ Group Name _____

Group # _____ Insured Party _____
FIRST NAME LAST NAME

Relation _____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel. (_____) _____

Address _____
ADDRESS CITY STATE ZIP

MODESTO ORAL SURGERY
IMPLANTS, FACIAL AND ORAL SURGERY
BRIAN K. HUTTO, DMD, MS.ED 209-522-5238

Name _____ Today's Date _____

DENTAL INSURANCE DISCLAIMER

It is very important for any dental patient to have some understanding of how dental insurance works. Your employer contracts with an insurance company, and the insurance company creates a custom tailored policy based on what your company is willing to pay as a premium. This policy is unique to your company, although it may share some similarities to other policies. The insurance company has the ability, based on the legal document "policy," to pay or not pay any claim at any time or to exclude certain procedures. Their legal relationship is with you, the patient, and not the dental office, which is a third-party provider.

The policy information can be very limited as to what the insurance company tells our office. What we do get, in bold letters, state "Notice: Provider acknowledges and understands that the information contained herein reflects current files. Claims will be processed according to benefit and membership information on file at the time of processing. Therefore, the information contained herein does not guarantee reimbursement."

Please understand, as a patient at our office, we do everything possible to ensure that you get your maximum insurance benefit. The insurance company processes a claim solely at their discretion and they can refuse or deny anything they choose. When you receive a treatment plan from our office, it is an estimate only based on what your insurance chooses to tell us. There are thousands of insurance policies out there; we do not have an in-depth knowledge of your particular plan.

It is important for you to have a copy of your policy and some understanding of it. This document is our attempt to avoid any financial misunderstandings. In the end, YOU are responsible for anything your insurance company does not cover for any reason.

I have read this Dental Insurance Disclaimer concerning my dental insurance coverage. I further understand that I will be billed and will be responsible to pay for any and all amounts not paid or covered by my dental insurer.

Signature of patient _____ Date _____
(Parent or Guardian if minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

"I acknowledge that I have received a copy of the office's Notice of Privacy Practices."

Please Print Patient Name _____

Signature of patient _____ Date _____
(Parent or Guardian if minor)

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

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HEALTH HISTORY

Name _____ Date _____

For the safety of our patients: Although oral surgeons primarily treat the area in and around your mouth, the entire body is connected. Health problems that you may have, or medication 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 are strictly confidential.

Reasons for today's office visit: _____

Height _____ Weight _____ Age _____

Occupation: _____

PAST MEDICAL HISTORY

	Yes	No
Are there any cultural, learning, or language barriers we need to be aware of?	❑	❑
Are you in good health?	❑	❑
Have there been any changes in your general health in the past year?	❑	❑
Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
Describe where		
Are you under the care of a physician?	❑	❑
If so, what are you being treated for? _____		
Physician's Name _____		
Physician's Phone _____ Date of last visit _____		
Have you had an artificial joint replacement (knee, hip, shoulder, etc)?	❑	❑
Describe where _____		
Have you had a heart valve replacement or vascular graft?	❑	❑

Have you had or do you currently have...	Yes	No
Rheumatic fever?	❑	❑
Damaged heart valves / mitral valve prolapse?	❑	❑
Heart murmur?	❑	❑
High blood pressure?	❑	❑
Low blood pressure?	❑	❑
Chest pain, angina?	❑	❑
Heart attack(s)?	❑	❑
Irregular heart beat?	❑	❑
Cardiac pacemaker?	❑	❑
Heart surgery?	❑	❑
Bronchitis, chronic cough?	❑	❑
Asthma?	❑	❑
Nasal / sinus problems / seasonal allergies?	❑	❑
Tuberculosis?	❑	❑
Emphysema/COPD?	❑	❑
Obstructive Sleep Apnea (OSA)?	❑	❑
Difficult breathing / other lung trouble?	❑	❑
Do you smoke?	❑	❑
Blood Transfusion?	❑	❑
Blood disorder (e.g. anemia)?	❑	❑
Bruise easily?	❑	❑

Have you had or do you currently have...	Yes	No
Bleeding tendency (abnormal bleeding)?	❑	❑
Jaundice, hepatitis or liver disease?	❑	❑
Infectious Mononucleosis?	❑	❑
Gallbladder trouble?	❑	❑
Osteoporosis?	❑	❑
Fainting spells?	❑	❑
Convulsions, epilepsy, seizures?	❑	❑
Stroke?	❑	❑
Thyroid trouble?	❑	❑
Diabetes?	❑	❑
Low blood sugar?	❑	❑
Kidney trouble?	❑	❑
Are you on dialysis?	❑	❑
Arthritis or joint disease?	❑	❑
Stomach ulcers?	❑	❑
Sexually transmitted diseases?	❑	❑
Problems with the immune system?	❑	❑
Delay in healing?	❑	❑
Cancer?	❑	❑
A tumor or growth?	❑	❑
X-ray treatment/chemotherapy?	❑	❑
Chronic fatigue / night sweats?	❑	❑
Are you on a diet?	❑	❑

Have you had or do you currently have...	Yes	No
A history of drug abuse?	❑	❑
A history of alcohol abuse?	❑	❑
Contact Lenses?	❑	❑
Eye disease / glaucoma?	❑	❑
Mental health problems?	❑	❑
A removable dental appliance?	❑	❑
Pain and/or clicking of the jaw?	❑	❑
Anesthetic complications?	❑	❑

Please list any previous reactions to anesthesia _____

_____

Other medical issues: _____

_____

WOMEN

Is there a possibility of pregnancy?	❑	❑
Are you nursing?	❑	❑
Are you taking birth control pills?	❑	❑

If pregnant, estimated delivery date:

_____/_____/_____

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.

FAMILY HISTORY:

Is there a family history of: (choose all that apply)

❑ Bleeding problems ❑ Diabetes ❑ Cancer ❑ Heart disease ❑ Anesthesia problems

Name _____ Date _____

ALLERGIES

Are you allergic to, or had a reaction to...	Yes	No	Are you allergic to, or had a reaction to...	Yes	No	Are you allergic to, or had a reaction to...	Yes	No
Local anesthetic (numbing meds)?	❑	❑	Sulfa drugs?	❑	❑	Latex or rubber products?	❑	❑
Sodium pentothal/Valium/other tranquilizers?	❑	❑	Other antibiotics?	❑	❑	Soy?	❑	❑
Penicillin?	❑	❑	Aspirin?	❑	❑	Eggs/yolks?	❑	❑
Amoxicillin?	❑	❑	Codeine or other narcotics?	❑	❑	Sulfites?	❑	❑
			Other medications?	❑	❑	Do you have any known allergies?	❑	❑

Please list any allergies other than drug allergies: _____

_____

MEDICATION & SURGICAL HISTORY

Are you now taking...	Yes	No	Are you now taking...	Yes	No	Are you now taking...	Yes	No
Any kind of medication, drug, pills?	❑	❑	Any natural product, herbal supplement or homeopathic remedy?	❑	❑	Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?	❑	❑
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?	❑	❑	Are you taking, or have you ever taken, bone density meds, or bisphosphonates such as Fosamax, Boniva, Actonel, Reclast, IV-Zometa, Aredia or Prolia in the past 12 years?	❑	❑	If so, please list: _____		
Have you ever taken diet pills?	❑	❑						

Please list any medications you are currently taking, including non-prescription meds, vitamins, herbals or supplements:

Medication	Dosage / Frequency	Medication	Dosage / Frequency

Please list any surgical or invasive procedures you have had:

Date	Significant Surgical and Invasive Procedures

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any other condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No

If so, please describe: _____

Do you wish to speak to the Doctor privately about anything? ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Tel. # H (_____)_____ Wk: (_____)_____

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 doctor, or any other staff member, responsible for any errors or omissions that I have made.

Signature of patient _____ **Date** _____
(Parent or Guardian if minor)

AUTHORIZATION

I authorize my surgeon and their 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 in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone concerning my appointment.

X _____ **X** _____ **X** _____
Signature of patient (Parent or Guardian if Minor) **Witness** **Date**

Reviewed by _____ **Date** _____