CHASE PRUITT
ORAL SURGERY

Patient Information: Date:____/____/____

First Name:_______________________ Middle Initial: ______ Last Name: __________________________

DOB: ___/___/___ SSN:_____-____-______ Sex:________ Email:_________________________________
Address: ____

City:____________________________ State: ____________________ ZIP:_______________________

Phone: _______________________________ Referring Doctor: _________________________________

Preferred Pharmacy: _________________________________ Phone: _____________________________

Emergency Contact: __________________________________ Phone: _____________________________

Primary Dental Insurance:

Policy Holder: _____________________________________ Relation: ____________________________

DOB: ___/___/___ SSN: ____-_____-_______ Sex:_________ Phone: ___________________________

Employer: ____ Insurance Company: __________________

Member ID: ____ Group #: ____________________________

Secondary Dental Insurance:

Policy Holder: _____________________________________ Relation: ____________________________

DOB: ___/___/___ SSN: ____-_____-_______ Sex:_________ Phone: ___________________________

Employer: ____ Insurance Company: __________________

Member ID: ____ Group #: ____________________________

Medical History: Have you had, or do you currently have:

Damaged heart valves/ mitral valve prolapse?.......... Y / N

Heart murmur? .... Y / N

High blood pressure? .... Y / N

HIV/AIDS?... Y / N

Heart attacks? .... Y / N

Irregular heart beat? .... Y / N

Heart surgery? .... Y / N

Difficulty breathing/ lung trouble? .... Y / N

Bleeding tendency/ abnormal bleeding?......... Y / N

Hepatitis, jaundice, or liver disease? .... Y / N

Convulsions/ epilepsy? .... Y / N

Stroke? .... Y / N

Diabetes?.. Y / N

Kidney trouble? .... Y / N

Asthma? .... Y / N
Sleep apnea/ CPAP? .... Y / N
Contagious disease? .... Y / N
Cancer, radiation therapy, or chemotherapy?............ Y / N
Immunity problems? .... Y / N

Tumor or growth? .... Y / N
Osteoporosis/ Osteopenia? .... Y / N
Mental health / anxiety/ depression? ....Y / N
Jaw pain/ clicking? .... Y / N
Delayed healing? .... Y / N

Social History:

Smoke/ Vape?.. Y / N
Chewing tobacco? .... Y / N

Marijuanna or recreational drug use?............ Y / N
Alcohol use? .... Y / N

Medications:

List all current medications.

____
____
____
____
____
____
____
____
____

Allergies:

List all allergies.

____
____
____
____

Any additional health related concerns the doctor should be made aware of?

____
____
____

Past Procedures:

Have you had any procedures or surgeries? Describe.

____
____
____
____

Have you had general anesthesia? Any complications? Describe.

____
____
____
____

Verification:

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 member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature: ____ Date: _____________________________

Release of Information:

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me

Signature: ____ Date: _____________________________

Fees and Payments:

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature: ____ Date: _____________________________

Authorization for Service:

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial 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 and / or mobile phone concerning my appointment.

Signature: ____ Date: _____________________________

Notice of Privacy Practices:

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: ____ Date: _____________________________