Horace K. Wood, DMD, PA
Oral & Maxillofacial Surgery

Patient Information

General Dentist _____ Referring Dentist _____

Miss Mrs. Ms. Mr. Name _____
(Circle one) First MI Last Nickname

Address _____
P.O. Box or Street City State Zip

Phone# Home _____ Cell _____ Wk _____ Email _____

Date of Birth _____ Male __ Female __ SS# _____ Occupation _____

Person Responsible for account (if other than patient)

Miss Mrs. Ms. Mr. Name _____
(Circle one) First MI Last Relationship to Pt

Address _____
P.O. Box or Street City State Zip

Phone# Home _____ Cell _____ Wk _____ Email _____

Date of Birth _____ Male __ Female __ SS# _____ Occupation _____

Dental Insurance _____ Phone _____

Claims Address _____
P.O. Box or Street City State Zip

Policy Holder _____ Relationship: Self Spouse Child Other
First MI Last

Policy Holder Date of Birth _____ ID# _____ SS# _____

Secondary Dental _____ Phone _____

Claims Address _____
P.O. Box or Street City State Zip

Policy Holder _____ Relationship: Self Spouse Child Other
First MI Last

Policy Holder Date of Birth _____ ID# _____ SS# _____

Medical Insurance _____ Phone _____

Claims Address _____
P.O. Box or Street City State Zip

Policy Holder _____ Relationship: Self Spouse Child Other
First MI Last

Policy Holder Date of Birth _____ ID# _____ SS# _____

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Medical Information

The answers that you provide to the following questions will help us determine the proper treatment for you. These records are kept confidential in our office.

Name of general dentist _____

Yes No Are you in good health?
Yes No Has there been any changes in your general health within the last year?
Yes No Are you now under the care of a physician? If so, what for?
_____
_____

Yes No Are you currently taking any prescriptions, non-prescriptions or herbal medicines? Please list:
_____
_____
_____
_____
_____

Yes No Have you ever had any prior operations, injuries or serious illnesses? If so, please list:
_____
_____
_____

Yes No Are you allergic to or ever had any bad reaction to any medicines including local or general anesthesia? If so, which ones?
_____
_____

Yes No Do you have any other allergies or reactions? (i.e. latex, eggs, milk, soybeans)
_____

Have you had any of the following medical conditions:
Do you have heart/cardiovascular problems
Yes No Rheumatic fever or rheumatic heart disease
Yes No Heart murmur
Yes No High or low blood pressure (circle one)
Yes No Chest pains
Yes No Previous heart attack
Yes No Ankle swelling
Yes No Pacemaker or artificial heart valves (circle one)
Yes No Bypass surgery or angioplasty (circle one)
Yes No Stroke
Yes No Lung Disease
Yes No Asthma
Yes No Bronchitis
Yes No Tuberculosis
Yes No COPD
Yes No Nervous Disorder
Yes No Epilepsy

Who referred you to our office _____

Yes No Seizures
Yes No Fainting
Yes No Breakdown
Yes No Psychiatric treatment
Yes No Blood disorder
Yes No Anemia
Yes No Clotting Disorder
Yes No Bleed or Bruise easily
Yes No Kidney disease
Yes No Liver disease
Yes No Hepatitis
Yes No Diabetes Type 1 ____ Type 2____
Yes No Thyroid disease
Yes No Glaucoma
Yes No Cancer Type/Location _____
Yes No Cancer Surgery
Yes No Radiation
Yes No Chemotherapy
Yes No Bone Disease (Osteoporosis) or taking any of the following medications (please circle): Bisphosphonates, Actonel, Fosamax, Boniva, Aredia, Zometa, Reclast, Prolia)
Yes No Immune system disorder
Yes No Organ or tissue transplant
Yes No AIDS/HIV
Yes No Blood transfusion
Yes No Artificial prosthesis (i.e. hip or knee)
Yes No Do you have difficulty opening your mouth or TMJ problems?
Yes No Are you wearing a removable denture or plate?
Yes No Are you pregnant or nursing? If so, how many months _____
Yes No Have you or anyone in your immediate family had difficulty with general anesthesia?
Yes No Do you snore while sleeping or have been diagnosed with sleep apnea?
Yes No Are you wearing contact lenses?
Yes No Do you smoke? Amount _____How many years _____
Yes No Do you have a disease or condition not mentioned above? Please list:
_____
Yes No Is there any history of alcohol or drug dependency?
Yes No Do you wish to talk to the doctor privately about anything?

I affirm that the above information is true and accurate to the best of my knowledge and that I had the opportunity to discuss my health history with my doctor.

_____

Print Patient's Name

If under 18yrs, Print Legal Guardian's Name & Relationship

_____

Signature of Patient or Legal Guardian

Date

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OFFICE AND FINANCIAL POLICIES

I authorize treatment by the doctor and supporting staff members.

We currently accept CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CARE CREDIT.
WE DO NOT OFFER PERSONAL PAYMENT PLANS.

I understand there may be a minimum charge of $50 for broken appointments without 24 hours notice.

I authorize assignment of benefits where applicable. If payment has not been received from the insurance company within 30 days of the date of service, I will accept full responsibility for payment in full within 30 days of notification.

All emergency dental services must be paid at time of service.

Patients, or Responsible Parties, are responsible for all fees incurred regardless of dental insurance. We do participate with a limited number of insurance companies. All copayments and deductibles are due at time of service. If you have insurance that we do not participate with, all payments are due at time of service. We will, as a courtesy, file your insurance claim.

A service charge of 1 ½% per month (18% per annum), minimum of $5.00, on the unpaid balance will be charged on all accounts exceeding 60 days.

I accept full responsibility for any legal or collection agency fees (currently 35%) should my account become delinquent.

I grant my permission for you, or your assignee, to telephone me at home, cell, or my work to discuss matters related to this form.

I have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

I have received a copy of this office's EDUCATION FOR PATIENTS REGARDING OPIOID USE.

(POLICIES ARE LOCATED ON OUR WEBSITE UNDER PATIENT INFORMATION – OFFICE POLICIES)

I have read the above conditions of treatment and payment and agree to their content.

_____

Print Patient's Name If under 18yrs, Print Legal Guardian's Name & Relationship

_____

Signature of Patient or Legal Guardian Date

508C Cynwood Drive, Easton, Maryland 21601
Phone: 410-770-3130 www.eastonoms.com