First Name	Middle	Last Name	Social Security #	Sex		Date of Birth	AGE	Marital Status			
				M	F			S	M	D	W

Street Address	Apt. #	City	State	Zip Code

Cell Phone	Home Phone	Email

Subscriber of Insurance (if not self) Name:	Insurance subscriber Date of Birth: Social Sec #
If Patient is a Minor **Parent/Guardian Name:**	**Students: please provide permanent address below**
Emergency Contact **Name: Phone:**	**Pharmacy Name and Location**
Dentist	**Physician**

PLEASE PROVIDE US WITH YOUR MEDICAL & DENTAL INSURANCE CARDS
If you do not have your insurance information at the time of your visit, payment is due in full.

Accurately answering these questions will help ensure safe and effective treatment. If you prefer, you may discuss your answers to this medical history privately with the doctor. ***Please circle each answer individually***

Have you had an operation, serious illness, or been hospitalized in the past 5 years? If so, what was the reason?	**YES**	**NO**
Do you take any drug(s), medicine(s), including non-prescription drugs or herbal remedies, blood thinners?	**YES**	**NO**
If yes, please list: *If you have a list please provide to the receptionist.*		
Have you ever taken bisphosphonates (e.g. Fosamax, Zometa, Reclast, etc.)?	**YES**	**NO**
Do you use or have you used recreational drugs (e.g. cocaine, marijuana, or ecstasy) within the last 6 months?	**YES**	**NO**
Are you allergic to Latex?	**YES**	**NO**
Do you have any drug allergies? **If yes, please list**:	**YES**	**NO**
Do you have difficulty with bleeding or healing from a cut, wound, or extraction?	**YES**	**NO**
Do you smoke, chew tobacco, or suffer from alcoholism? If **YES**, please circle which one.	**YES**	**NO**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? ***Please circle each answer individually***

Heart Disease	**YES**	**NO**	Diabetes	**YES**	**NO**	Cancer	**YES**	**NO**
Heart Murmur / MVP	**YES**	**NO**	AIDS, ARC or HIV	**YES**	**NO**	Radiation Therapy	**YES**	**NO**
Heart Valve Replacement	**YES**	**NO**	Hepatitis(Type:)	**YES**	**NO**	Chemotherapy	**YES**	**NO**
Angina	**YES**	**NO**	Jaundice	**YES**	**NO**	Kidney Disease	**YES**	**NO**
Pacemaker / Defibrillator	**YES**	**NO**	Liver Disease	**YES**	**NO**	Stomach Ulcer/GERD	**YES**	**NO**
Rheumatic Fever	**YES**	**NO**	Stroke	**YES**	**NO**	Venereal Disease	**YES**	**NO**
Lung Disease	**YES**	**NO**	Seizure Disorder	**YES**	**NO**	Artificial Joints	**YES**	**NO**
Shortness Of Breath	**YES**	**NO**	Nerve Disorder	**YES**	**NO**	TMJ	**YES**	**NO**
Asthma	**YES**	**NO**	Mental Illness	**YES**	**NO**	Arthritis	**YES**	**NO**
Sinus Disease	**YES**	**NO**	Thyroid Disease	**YES**	**NO**	Tuberculosis	**YES**	**NO**
Glaucoma	**YES**	**NO**	Migraines	**YES**	**NO**	Do you pre-medicate with antibiotics for dental work	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	Anemia	**YES**	**NO**			

Have you or an immediate family member had any problems associated with anesthesia?	**YES**	**NO**
WOMEN ONLY: Are you pregnant, nursing, menopausal or on birth control? If **YES** please circle which one	**YES**	**NO**
Do you have any other disease, condition, problem or special treatment needs not listed above? **PLEASE EXPLAIN:**	**YES**	**NO**

We make every effort to keep the cost of our fees reasonable. We require payment at the time of service and accept cash, checks, Visa, MasterCard, Discover, and American Express. A service charge of 1.5% per month (18% per annum) will be charged on any unpaid balance within 60 days of treatment. Any check returned to us due to insufficient funds will result in a $35 service charge to your account. If you have dental and/or medical insurance, we will be glad to submit claims for you but we need your insurance information at the time services are rendered.
Furthermore, you should understand that:

1) Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. Benefits payable, if any, by your insurance company are determined once they receive and review the claim.
2) If your insurance policy requires a referral and you receive treatment without such, you assume full financial responsibility.
3) If your insurance company has not made payment within 45 days, we may ask you to assist us in getting your claim processed for payment or for payment to be made by you.
4) In cases of divorced parents, the parent who brings the child in for treatment will be deemed responsible for payment.
5) 48 hour notice is required for cancellation of appointments. If not a $50 cancellation fee will be applied to your account.

I hereby authorize the release of information necessary to submit my claim(s) and assign all payment for services rendered to myself or my dependents to Arlington Oral Surgery. I permit messages to be left on my phone/mobile phone and email concerning my appointment, treatment, and payment. I understand and agree that I am ultimately responsible for payment and certify that this information is true and correct to the best of my knowledge.

x_____ _____/_____/_____ _____

Patient, Parent or Guardian's Signature **Date** **Doctor's Signature** **{10/2024}**