

*Oral Surgery Associates of Charlotte*

*Dr. Tara A. Valiquette, DMD & Dr. Erik F. Reitter, DDS*

**Patient Information: Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

❏ Mr. ❏ Mrs. ❏ Ms. First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M:\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ❏ Male ❏ Female Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_ Soc. Sec. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel.(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell.(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s Lic.#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a student?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Full-Time or Part Time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party / Guarantor Information (If under 18 or full time student):**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M:\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel.(\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell.(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

|  |  |
| --- | --- |
| **Primary Dental Insurance** | **Primary Medical Insurance** |
| Insurance Co. Name: | Insurance Co. Name: |
| Claims Address: | Claims Address: |
| Phone #: | Phone #: |
| Policy #: Group#: | Policy #: Group#: |
| Policy Holder: Relation to pt: | Policy Holder: Relation to pt: |
| Home Address: | Home Address: |
| SS #: Date of Birth: | SS #: Date of Birth: |
| Employer: Home Phone: | Employer: Home Phone: |

**I certify that I have read and I understand the questions above. I will not hold my surgeon or any member of his / her staff responsible for any errors or omissions that I have made in completing this form.**

**Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you in good health? **Yes / No** Height:\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you under the care of a physician? **Yes / No Please Describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had or do you currently have:**

|  |  |
| --- | --- |
| Heart Condition: Yes / No | Please Describe: |
| High Blood Pressure / Low Blood Pressure (Circle One ) |  |
| Rheumatic Fever: Yes / No |  |
| Lung / Breathing Condition: Yes / No | Please Describe: |
| Asthma: Yes / No |  |
| Emphysema : Yes / No |  |
| Tuberculosis: Yes / No |  |
| Tobacco Use: Yes / No | Please Describe: |
| Blood / Bleeding Condition: Yes / No | Please Describe: |
| Hepatitis, Jaundice, Liver disease: Yes / No |  |
| Convulsions / Epilepsy: Yes / No |  |
| Stroke / Heart Attack: Yes / No |  |
| Thyroid Trouble: Yes / No |  |
| Diabetes: Yes / No  | Last Reading: Date: |
| Kidney Condition: Yes / No | Please Describe: |
| Bone Condition: Yes / No | Please Describe: |
| Infectious / Contagious Diseases: Yes / No | Please Describe: |
| Cancer / Radiation Treatment: Yes / No | Please Describe: |
| History of Alcohol / Drug Abuse: Yes / No |  |
| Reaction to general anesthesia in the past: Yes / No |  |

**Allergies / Medications**

|  |  |
| --- | --- |
| Please list any allergies including drugs, seasonal, food | Please list all of you current medications including herbal supplements: |
|  |  |
|  |  |

**I certify that I have read and I understand the questions above. I will not hold my surgeon or any member of his / her staff responsible for any errors or omissions that I have made in completing this form.
Patient/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reviewed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**