Parkside Oral Surgery and Implant Center ● Wendy Liao, D.D.S.
2525 Santa Clara Ave ● Alameda, CA 94501
510-865-1114 (Phone) ● 510-227-6212 (Fax)

Today's Date_____

Patient Information

Patient's Name _____Birthdate _____Age _____
(First) (MI) (Last) (mo/day/yr)

(please circle one) Mr. Mrs. Ms. Miss Dr. Email_____

Home Phone # (____)_____Cell # (____)_____ Work # (____)_____

Home Address_____City_____ State____Zip_____

Social Security #:_____-____-_____Driver's License #:_____ Issuing State_____

Patient's Employer/Occupation_____

If the patient is a student, name of school attending_____

Have you or a member of your family ever been a patient in this office before? Name_____

Parent/Guardian Information – Complete if the patient is a minor.

Name _____Home # (____)_____Cell # (____)_____

Address_____City_____ State____Zip_____

Employer/Occupation_____Work # (_____)_____

Relationship to Patient ☐ Father ☐ Mother ☐Other_____

If the patient's parents are divorced, what are the legal custody arrangements? ☐ Joint ☐ Sole

Billing Address of Responsible Person

Name _____Contact # (____)_____Relationship to patient_____

Home Address_____City_____ State____Zip_____

Insurance Information

	Primary Dental	Secondary Dental	Medical
Policy Holder's Relation to Patient			
Policy Holder's Name			
Policy Holder's SS#/ID#			
Policy Holders Date of Birth			
Policy Holder's Employer			
Name of Insurance Company			
Address of Insurance Co.			
Phone # of Insurance Co.			
Group or Policy #			
Union or Local #			

Name of Dentist _____ Name of Orthodontist_____

Name of Physician_____ Kaiser ID#_____

Pharmacy you would like to use_____Phone #_____

Who may we thank for referring you?_____

In case of Emergency Notify _____ Phone #_____

Health History

Chief Dental Complaint Today:_____

Answer all questions by circling Yes (Y) or No (N) - All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

     _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____

     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I certify that I have read and understand all 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 surgeon, or any other member of her staff, responsible for any errors or omissions that I have made in the completion of this form.

Date Signature of patient

Fees and Payments

We make every effort to keep down the cost of your oral surgical 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.

Date Signature of patient

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.

Date Signature of patient

Authorization

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.

Date Signature of patient Witness

Appointment Policy

If you are unable to keep an appointment, a 48-hour notice of cancellation is greatly appreciated. If an appointment is not kept or cancelled within 24 hours, you will be subject to a late cancellation fee of $100.

Dr. Liao will try her best to stay on schedule to minimize your waiting. However, due to the fact that this is a surgery office, various circumstances may lengthen the time allocated for a procedure. Emergency cases can also arise and cause delays. We appreciate your understanding and patience in the event that your appointment is delayed.

Date Signature of patient

If this form is filled and signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient:_____