QUEENSBORO ORAL SURGERY ASSOCIATES, PLLC

Oral, Maxillofacial & Implant Surgery

Dr. Howard A. Ochs / Dr. Maria A. Dourmas

(❑ Mr. ❑ Mrs. ❑ Miss. ❑ Dr.) Patient's Name______________________________Date______________
Street Address____________________City______________State________Zip________________
Phone Number (Home)________________(Bus.)________________Social Sec. #________________
Date of Birth______________________Occupation/School______________________________
Email:____________________________Referred By __________________________________
If patient is a minor, parent or guardians name_____________________________________
Chief Complaint: What is the reason for this visit?__________________________________

Medical History

Do you have or have you had any of the following diseases or problems? Answer all questions, circle Y or N.

Cough, Cold or Flu	Y N	Heart Murmur	Y N	Cancer	Y N	Glaucoma	Y N
Asthma	Y N	Angina	Y N	Chemotherapy	Y N	Diabetes	Y N
Bronchitis	Y N	Irregular Heart Beat	Y N	Stroke	Y N	Artificial Joints	Y N
Sinusitis	Y N	Pacemaker	Y N	Liver Disease	Y N	Blood Transfusions	Y N
Emphysema	Y N	Artificial Heart Valve	Y N	Kidney Disease	Y N	Blood Disease	Y N
Lung Disease	Y N	Rheumatic Fever	Y N	Thyroid Disease	Y N	Immunosuppressive Disorder	Y N
Shortness of Breath	Y N	High Blood Pressure	Y N	Hepatitis Type: ________	Y N		
Heart Disease	Y N	Seizures	Y N	Ulcers	Y N	Drug/Alcohol Abuse	Y N

Any other serious medical conditions? ____
As far as you know, do you require any premedication prior to any dental treatment or surgery?______________
Do you have a tendency to bleed, bruise or swell easily?______________________________
Are you taking any type of medication? List:______________________________________
Do you have any allergies or adverse reactions to any medications? List:________________
Are you presently under the care of a physician and for what reason?_________________
❑ Have you undergone a recent operation? ❑ Do you smoke? ❑ Wear contact lenses?
Woman: If pregnant, what month?________________Taking birth control pills?______________

For anesthesia patients:

What time did you last eat or drink?____
Have you had any complications or unfavorable reactions?_______________________
Patient Signature____

Medical History Update:

Date	Comments	Signature
____________	______________________________	____________________
____________	______________________________	____________________
____________	______________________________	____________________

We are happy to accept insurance assignment, but the amount not covered must be paid on day of service.

Dental: Primary Insurer________________Policyholder______________ID#_________Group#_______
Dental: Secondary Insurer______________Policyholder______________ID#_________Group#_______
Medical: Primary Insurer________________Policyholder______________ID#_________Group#_______
Medicare#________________________________Medicaid #______________________________

Please make financial arrangements with receptionist prior to surgery.

Person financially responsible for this account if other than patient____________Relationship to patient________
Mailing address if different from above____
Method of Payment:
❑ Cash ❑ Check ❑ MasterCard ❑ Visa ❑ American Express ❑ Diners ❑ Insurance

For Assignable Dental/Medical Plans Including Medicare:

I, the undersigned, have insurance coverage with ____________and assign directly to the doctor any benefits otherwise payable to me for services rendered. I will be responsible for any payment that my insurance doesn't cover up to the prearranged fee. I also understand that my signature authorizes the release of any insurance information necessary to file this claim.
Signature____Date________________________