Dr Harold Patino
Oral Maxillofacial
& Implant Surgery

PATIENT

First (Legal) Name: _____ Middle Initial: ____ Last Name: _____ Nickname: _____

Male / Female Marital Status: ____ Date of Birth: _____ Age:____ SS#: _____

Address: _____ Primary #: _____Home:__Cell:__

City: _____ State: _____ Zip:_____ Alternate #: _____Home:__Cell:__

Patient Email: _____ School Name: _____

Parent Email: _____

Reason for this appointment? _____

Is the reason for your appointment the result of an accident or injury? Yes ____ No _____

Source of Referral (specify): Doctor: _____ Online Review/Site: _____ Friend: _____

Name of General Dentist: _____ Orthodontist: _____

Have you, a friend or a family member been seen/treated by Dr Patino? If so, who? _____

_____

MEDICAL INFORMATION

Please list any **allergies to medications**? _____

Any problems with eggs, lecithin, soy or **latex**? _____

Please list all medications you're currently taking: _____

Hospitalizations, surgeries or ER visits (last 5 yrs): _____

_____

Height _____ Weight_____ Do you smoke / Vape?_____ Amount per day?_____ How many years? ___

Are you under the care of a physician? _____ Reason? _____

Primary Care Physician: _____ Phone #: _____

Specialist: _____ Phone #: _____

Do you have any history of the following:

____ Asthma / Wheezing
____ Current use of Inhaler:Yes__No_
____ Shortness of Breath
____ Respiratory Disease / Bronchitis
____ Sleep Apnea (Use of CPAP:___)
____ Sinus Problems
___ Tuberculosis (Diagn **or** Vaccine)
___ Thyroid Problems
___ Epilepsy / Seizures / Fainting
___ Headaches
___ Knee, Hip, Joint Replacement
___ Arthritis / Rheumatism
___ Wear Contacts

___ Diabetes (Type: _____)
___ Bleeding Problems / Hemophilia
___ Blood Disease
___ High Blood Pressure
___ Low Blood Pressure
___ Taking Blood Thinners / Aspirin
___ Heart Murmur
___ Pacemaker / Stent
___ Stroke (Date:_____)
___ Cancer (Type: _____)
___ Radiation / Chemotherapy
(Date: _____)
___ High Cholesterol

___ Liver Disease
___ Hepatitis (Type: _____)
___ Kidney Problems
___ HPV (Diagnosis or Vaccine)
___ HIV / AIDS
___ Chemical Dependency
___ Psychiatric Condition (Ex: depression):
(_____)
___ Cognitive Condition (i.e., ADHD):
(_____)
___ C DIFF
___ Pregnant
___ Breast Feeding

Other Medical Conditions: No___ Yes: _____

Traveled outside of the US in the last 3 months? ___ No ___ Yes (If yes, please specify country _____)

_____ _____ _____

Signature of Patient or Legal Guardian Print Full Name Date

LEGAL GUARDIANSHIP (FOR MINORS ONLY-UNDER 18)

If you are not the patient's parent, do you have a Medical Power of Attorney or proof of legal guardianship with you today? ___Yes ___ No

***** Please be advised that HMO medical plans do not provide coverage for out-of-network providers. Dr. Patino is considered out-of-network for all medical plans.***

SUBSCRIBER FOR PRIMARY INSURANCE

Legal Name:_____ Relationship to Patient: _____

SS#: _____ DOB: _____ Marital Status: ___S___M___D

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Employer: _____ Work Phone: _____

Primary Dental Insurance:_____ PPO( ) HMO( ) Plan ID: _____

Group: _____

Primary Medical Insurance:_____ PPO( ) HMO( ) Plan ID:_____

Group: _____

SUBSCRIBER FOR SECONDARY INSURANCE

Legal Name: _____ Relationship to Patient: _____

SS#: _____ DOB: _____ Marital Status: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Employer: _____ Work Phone: _____

Secondary Dental Insurance:_____ PPO( ) HMO( ) Plan ID: _____

Group: _____

Secondary Medical Insurance:_____ PPO( ) HMO( ) Plan ID:_____

Group: _____

FINANCIALLY RESPONSIBLE PARTY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I have read all the information on this form and certify it to be true and correct to the best of my knowledge. Additionally, I will notify you of any changes in my status (address, insurance coverage, marital status, etc).

Name of person responsible for payment: _____

_____ _____ _____

Signature of Patient or Legal Guardian Print Full Name Date