DATE: _____

# Oral Surgery

## FINANCIAL POLICY:

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. Some procedures may be covered under your major medical insurance. Some procedures are covered only under your dental policy.

It is your responsibility to provide all necessary insurance eligibility, identification and referral information and to notify our office of any information changes when they occur. Failure to provide all required information may necessitate patient payment for all charges.

When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

If you incur a credit balance from a claim, that credit balance will be applied to any outstanding balance on your account before a refund is issued.

You will be responsible for any services not covered by your plan.

Financial arrangements for future treatment will be discussed at the time of your consultation. For most scheduled procedures your estimated co-pay/co-insurance will be required prior to treatment. If your procedure is not covered by your plan, the balance is due in full prior to treatment.

At your request we can file an insurance pre-determination. Pre-determinations are only estimates and do not always reflect exact reimbursement.

Some insurance companies, because we are not in their network, will reimburse you directly. Because of this, we may require payment in full for all services.

Payment is due 60 days after charges are incurred regardless of insurance payment. After this time, finance charges will be applied to your account at 1-1.5% per month (18% per year).

All checks returned as “non-sufficient funds” will incur a $30 charge.

**You will receive monthly statements as a reminder to follow-up with your insurance company. Please contact your insurance company 30 days after services are rendered to be sure your claim is being processed. Insurance reimbursement is ultimately the responsibility of the patient.**

In the event of an overpayment, a refund will be promptly issued to the person listed as the guarantor on the account.

**BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE BLUE RIDGE ORTHODONTICS FINANCIAL POLICY. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT.**

**PATIENT NAME:** _____

**GUARANTOR NAME (IF NOT PATIENT):** _____

GUARANTOR MUST BE PRESENT TO ACCEPT FINANCIAL RESPONSIBILITY. THE PERSON WHO SIGNS THE FINANCIAL POLICY WILL BE LISTED AS THE GUARANTOR.

**BILLING ADDRESS:** _____

_____

**SIGNATURE:** _____ **DATE:** _____

THE PERSON WHO SIGNS WILL BE LISTED AS THE GUARANTOR

# Oral Surgery

DATE: _____

## PATIENT INFORMATION:

FIRST NAME: _____ NICKNAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____
SEX: ⊙M ○F DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____ EMAIL ADDRESS: _____
ADDRESS: _____ PO BOX/APT #: _____ CITY: _____ STATE: _____ ZIP: _____
TELEPHONE: CELL: _____ HOME: _____ WORK: _____
MARITAL STATUS: ○S ○M ○W ○D IF STUDENT: ☐FULL-TIME ☐PART-TIME NAME OF SCHOOL: _____
EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____ PHONE NUMBER: _____
PRIMARY PHYSICIAN: _____ PHONE NUMBER: _____
DENTIST: _____ ORTHODONTIST: _____ REFERRED BY: _____
HOW DID YOU HEAR ABOUT US? _____
HAS A MEMBER OF YOUR FAMILY BEEN SEEN IN OUR PRACTICE? WHO? _____

MOTHER'S NAME: _____ TELEPHONE: CELL: _____ HOME: _____ WORK: _____
ADDRESS: _____ SOCIAL SECURITY #: _____
FATHER'S NAME: _____ TELEPHONE: CELL: _____ HOME: _____ WORK: _____
ADDRESS: _____ SOCIAL SECURITY #: _____
WHO HAS ACCOMPANIED YOU TO YOUR APPOINTMENT TODAY? ☐MOTHER ☐FATHER ☐OTHER: _____

## PRIMARY MEDICAL INSURANCE COMPANY:

EMPLOYER: _____
BUS. ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
BUS. TEL.: _____ PLAN: _____
INS. CO. NAME: _____ I.D.#: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
TEL.: _____ GROUP NAME: _____
GROUP #: _____ INSURED PARTY: _____
RELATION: _____ BIRTH DATE: _____ SEX: ☐M ☐F
S.S.#: _____ TEL.: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

## SECONDARY MEDICAL INSURANCE COMPANY:

EMPLOYER: _____
BUS. ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
BUS. TEL.: _____ PLAN: _____
INS. CO. NAME: _____ I.D.#: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
TEL.: _____ GROUP NAME: _____
GROUP #: _____ INSURED PARTY: _____
RELATION: _____ BIRTH DATE: _____ SEX: ☐M ☐F
S.S.#: _____ TEL.: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

## PRIMARY DENTAL INSURANCE COMPANY:

EMPLOYER: _____
BUS. ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
BUS. TEL.: _____ PLAN: _____
INS. CO. NAME: _____ I.D.#: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
TEL.: _____ GROUP NAME: _____
GROUP #: _____ INSURED PARTY: _____
RELATION: _____ BIRTH DATE: _____ SEX: ☐M ☐F
S.S.#: _____ TEL.: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

## SECONDARY DENTAL INSURANCE COMPANY:

EMPLOYER: _____
BUS. ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
BUS. TEL.: _____ PLAN: _____
INS. CO. NAME: _____ I.D.#: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)
TEL.: _____ GROUP NAME: _____
GROUP #: _____ INSURED PARTY: _____
RELATION: _____ BIRTH DATE: _____ SEX: ⊙M ○F
S.S.#: _____ TEL.: _____
ADDRESS: _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

I authorize Blue Ridge Orthodontics to release any information for insurance purposes. I hereby authorize payment directly to Blue Ridge Orthodontics.

PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR)

I certify that the information on this form is correct. I understand that I am responsible for any balance on this account, even if I have medical and/or dental coverage.

PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR)

DATE: _____

# Oral Surgery

## INFORMED CONSENT FOR ORAL SURGERY & ANESTHESIA:

**PLEASE INITIAL NEXT TO EACH PARAGRAPH TO INDICATE IT HAS BEEN READ.**

X _____ **1.** THIS IS MY CONSENT FOR DR(S). JAMES HOWELL, RICK KAPITAN, WAHEED MOHAMED AND/OR ANY ORAL AND MAXILLOFACIAL SURGEON WHO IS WORKING WITH HIM/THEM TO PERFORM THE FOLLOWING TREATMENT / PROCEDURE /SURGERY:

_____

_____

AS PREVIOUSLY EXPLAINED TO ME, OR OTHER PROCEDURES DEEMED NECESSARY OR ADVISABLE AS NECESSARY TO COMPLETE THE PLANNED OPERATION.

X _____ **2.** I UNDERSTAND THAT THE PURPOSE OF THE PROCEDURE/SURGERY IS TO TREAT AND POSSIBLY CORRECT MY DISEASED ORAL/MAXILLOFACIAL TISSUES OR TO FACILITATE OTHER TYPES OF DENTAL TREATMENT SUCH AS ORTHODONTIC OR PROSTHETIC RESTORATION. THE DOCTOR HAS ADVISED ME THAT IF THIS CONDITION PERSISTS WITHOUT TREATMENT OF SURGERY, MY PRESENT ORAL CONDITION WILL PROBABLY WORSEN IN TIME, AND THE RISKS TO MY HEALTH MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING: SWELLING, PAIN, INFECTION, CYST FORMATION, PERIODONTAL (GUM) DISEASE, DENTAL DECAY, MAL-OCCLUSION (ABNORMAL BITE), PATHOLOGIC FRACTURE OF JAW, PREMATURE LOSS OF TEETH, AND /OR PREMATURE LOSS OF BONE. I HAVE BEEN INFORMED OF POSSIBLE ALTERNATIVE METHODS OF TREATMENT, IF ANY.

X _____ **3.** A DOCTOR HAS EXPLAINED TO ME THAT THERE ARE CERTAIN INHERENT AND POTENTIAL RISKS IN ANY TREATMENT PLAN OR PROCEDURE, AND IN THIS SPECIFIC INSTANCE SUCH OPERATIVE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

A. POSTOPERATIVE DISCOMFORT, SWELLING, AND BRUISING THAT MAY NECESSITATE SEVERAL DAYS OF HOME RECUPERATION.
B. HEAVY BLEEDING THAT MAY BE PROLONGED.
C. INJURY TO ADJACENT TEETH AND FILLINGS.
D. POSTOPERATIVE INFECTION REQUIRING ADDITIONAL TREATMENT.
E. STRETCHING OF THE CORNERS OF THE MOUTH WITH RESULTANT CRACKING AND BRUISING.
F. RESTRICTED MOUTH OPENING FOR SEVERAL WEEKS.
G. POSSIBLE TRAUMA TO THE JAW JOINTS AND MUSCLES.
H. BREAKAGE OF THE JAW.
I. INJURY TO THE NERVE UNDERLYING THE TEETH RESULTING IN NUMBNESS OR TINGLING OR PAIN OF THE LIP, CHIN, GUMS, CHEEK, TEETH AND/OR TONGUE ON THE OPERATED SIDE; THIS MAY PERSIST FOR SEVERAL WEEKS, MONTHS, OR IN REMOTE INSTANCES, PERMANENTLY.
J. OPENING OF THE SINUS (A NORMAL CAVITY SITUATED ABOVE THE UPPER TEETH) REQUIRING ADDITIONAL SURGERY.
K. DECISION TO LEAVE A SMALL PIECE OF ROOT IN THE JAW WHEN REMOVAL WOULD REQUIRE EXTENSIVE SURGERY.
L. OTHER: _____

X _____ **4.** IF ANY UNFORESEEN CONDITIONS SHOULD ARISE IN THE COURSE OF THE OPERATION, CALLING FOR A DOCTOR'S JUDGMENT OR FOR PROCEDURE(S) IN ADDITION TO OR DIFFERENT FROM THOSE NOW CONTEMPLATED, I REQUEST AND AUTHORIZE THE DOCTOR TO DO WHATEVER HE/SHE MAY DEEM ADVISABLE.

X _____ **5.** NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN TO ME THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. DUE TO INDIVIDUAL PATIENT DIFFERENCES, THERE EXISTS A RISK OF FAILURE, RELAPSE, SELECTIVE RETREATMENT, OR WORSENING OF MY PRESENT CONDITION DESPITE THE CARE PROVIDED. HOWEVER, IT IS THE DOCTOR'S OPINION THAT THERAPY WOULD BE HELPFUL, AND THAT A WORSENING OF MY CONDITION WOULD OCCUR SOONER WITHOUT THE RECOMMENDED TREATMENT.

X _____ **6.** I CONSENT TO ADMINISTRATION OF SUCH LOCAL AND/OR GENERAL ANESTHESIA AS DEEMED NECESSARY BY DR(S). JAMES HOWELL, RICK KAPITAN, WAHEED MOHAMED AND/OR HIS/HER DESIGNATED ASSISTANT TO ACCOMPLISH THE PROPOSED PROCEDURE.

X _____ **7.** I UNDERSTAND THAT CERTAIN ANESTHETIC RISKS, WHICH COULD INVOLVE SERIOUS BODILY INJURY, ARE INHERENT IN ANY PROCEDURE THAT REQUIRES A GENERAL ANESTHETIC.

DATE: _____

# Oral Surgery

## INFORMED CONSENT FOR ORAL SURGERY & ANESTHESIA, PG 2:

X _____ **8.** I AGREE AND UNDERSTAND I AM NOT TO HAVE AND/OR HAVE HAD ANYTHING TO EAT OR DRINK FOR SIX (6) HOURS BEFORE MY SURGERY IF UNDERGOING THE PROCEDURE WITH INTRAVENOUS SEDATION.

X _____ **9.** MEDICATIONS, DRUGS, ANESTHETIC AND PRESCRIPTIONS MAY CAUSE DROWSINESS AND LACK OF AWARENESS AND COORDINATION, WHICH CAN BE INCREASED BY THE USE OF ALCOHOL OR OTHER DRUGS; THUS I HAVE BEEN ADVISED NOT TO OPERATE ANY VEHICLE, AUTOMOBILE OR HAZARDOUS DEVICES, OR WORK, WHILE TAKING SUCH MEDICATIONS AND/OR DRUGS; OR UNTIL FULLY RECOVERED FROM THE EFFECTS OF SAME. I UNDERSTAND AND AGREE NOT TO OPERATE ANY VEHICLE OR HAZARDOUS DEVICE FOR AT LEAST TWENTY-FOUR (24) HOURS AFTER MY RELEASE FROM SURGERY OR UNTIL FURTHER RECOVERED FROM THE EFFECTS OF THE ANESTHETIC MEDICATION AND DRUGS THAT MAY HAVE BEEN GIVEN TO ME IN THE OFFICE OR HOSPITAL FOR MY CARE. I AGREE NOT TO DRIVE MYSELF HOME AFTER SURGERY AND WILL HAVE A RESPONSIBLE ADULT DRIVE ME OR ACCOMPANY ME HOME AFTER MY DISCHARGE FROM SURGERY.

X _____ **10.** I HAVE HAD AN OPPORTUNITY TO DISCUSS WITH DR(S). JAMES HOWELL, RICK KAPITAN AND WAHEED MOHAMED PAST MEDICAL AND HEALTH HISTORY INCLUDING ANY SERIOUS PROBLEMS AND/OR INJURIES.

X _____ **11.** I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF DR(S). JAMES HOWELL, RICK KAPITAN AND WAHEED MOHAMED WHILE I AM UNDER HIS/THEIR CARE, REALIZING THAT ANY LACK OF THE SAME COULD RESULT IN A LESS THAN OPTIMUM RESULT.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, CONSENT TO THE OPERATION AND THE EXPLANATION REFERRED TO OR MADE, AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. I ALSO STATE I READ AND WRITE ENGLISH.

**PATIENT NAME:** _____

**SIGNATURE:** _____
PATIENT, PARENT OR LEGAL GUARDIAN

**WITNESS:** _____

**DATE:** _____

**DOCTOR SIGNATURE:** _____

**WITNESS:** _____

**DATE:** _____

DATE: _____

# Oral Surgery

## AUTHORIZATION FOR RELEASE OF INFORMATION:

NAME OF PATIENT: _____ DATE OF BIRTH: _____

**BLUE RIDGE ORTHODONTICS IS AUTHORIZED TO RELEASE PROTECTED HEALTH AND/OR FINANCIAL INFORMATION ABOUT THE ABOVE NAMED PATIENT IN THE FOLLOWING MANNER AND TO IDENTIFIED PERSONS.**

**ENTITY TO RECEIVE INFORMATION**
WRITE EACH PERSON/ENTITY THAT YOU APPROVE TO RECEIVE INFORMATION.

| NAME OF PERSON/ENTITY | RELATIONSHIP | PHONE/CONTACT |
|---|---|---|
| | | |
| | | |
| | | |

**DESCRIPTION OF INFORMATION TO BE RELEASED**
CHECK WHAT CAN BE PROVIDED TO THE PERSON/ENTITY.

| ALL | TREATMENT | FINANCIAL |
|---|---|---|
| ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ |
| ☐ | ☐ | ☐ |

**WE MAY SEND PRIVATE HEALTH INFORMATION SUCH AS APPOINTMENT CONFIRMATION, PROCEDURE INSTRUCTIONS, AND FINANCIAL INFORMATION TO YOUR EMAIL, YOUR CELL PHONE, YOUR ANSWERING MACHINE AND/OR YOUR VOICEMAIL. PLEASE INDICATE THE TYPES OF COMMUNICATION YOU ARE WILLING TO RECEIVE.**

FOR **EMAIL AND/OR TEXT COMMUNICATION** I UNDERSTAND THAT IF INFORMATION IS NOT SENT IN AN ENCRYPTED MANNER THERE IS A RISK IT COULD BE ACCESSED INAPPROPRIATELY. I STILL ELECT TO RECEIVE EMAIL AND/OR TEXT COMMUNICATION AS SELECTED.

- ☐ EMAIL: _____
- ☐ TEXT (TO THE CELL NUMBER LISTED ON PATIENT INFORMATION SHEET)
- ☐ ANSWERING MACHINE/VOICE MAIL (ALL NUMBERS LISTED ON PATIENT INFORMATION SHEET)

### PATIENT RIGHTS:

- I HAVE THE RIGHT TO REVOKE AUTHORIZATION AT ANY TIME.
- I MAY INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED AS DESCRIBED IN THIS DOCUMENT.
- REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.
- INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

**THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.**

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____
PATIENT, PARENT OR LEGAL GUARDIAN

WITNESS: _____ RELATIONSHIP: _____
SIGNATURE - PRACTICE REPRESENTATIVE

DATE: _____

# Oral Surgery

BLUE RIDGE ORTHODONTICS

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

NAME OF PATIENT: _____ DATE OF BIRTH: _____

I UNDERSTAND I MAY RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE ABOVE NAMED PRACTICE IF I REQUEST ONE.

PATIENT NAME: _____ DATE: _____

## FOR OFFICE USE ONLY

**WE WERE UNABLE TO OBTAIN A WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES BECAUSE:**

- ☐ AN EMERGENCY EXISTED & A SIGNATURE WAS NOT POSSIBLE AT THE TIME.
- ☐ THE INDIVIDUAL REFUSED TO SIGN.
- ☐ A COPY WAS MAILED WITH A REQUEST FOR A SIGNATURE BY RETURN MAIL.
- ☐ UNABLE TO COMMUNICATE WITH THE PATIENT BECAUSE _____
- ☐ OTHER _____

PREPARED BY: _____

SIGNATURE: _____ DATE: _____

DATE: _____

# Oral Surgery

## MEDICAL INFORMATION:

NAME OF PATIENT: _____ AGE: _____ WEIGHT: _____

| | YES | NO |
|---|---|---|
| 1. ARE YOU ALLERGIC TO ANY MEDICINES, LATEX, EGGS OR SOYBEANS? (LIST ALLERGEN & REACTION) | ☐ | ☐ |
| 2. DO YOU TAKE ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER), SUPPLEMENTS OR HERBAL THERAPY REGULARLY NOW? (PLEASE LIST NAME, STRENGTH & FREQUENCY OF CURRENT MEDICATIONS) | ☐ | ☐ |
| 3. ARE YOU OR HAVE YOU TAKEN MEDICATION FOR DECREASED BONE DENSITY? (LIST BELOW) | ☐ | ☐ |
| 4. HAVE YOU TAKEN ANY KIND OF MEDICATION REGULARLY DURING THE PAST YEAR? (LIST BELOW) | ☐ | ☐ |
| 5. HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST TWO YEARS? | ☐ | ☐ |
| 6. ARE YOU NOW OR HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST TWO YEARS? | ☐ | ☐ |
| 7. HAVE YOU EVER HAD ANY TYPE OF SURGERY? (LIST BELOW) | ☐ | ☐ |

8. HAVE YOU NOW OR IN THE PAST HAVE YOU HAD PROBLEMS WITH AND/OR TREATMENT FOR:

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| HEART TROUBLE | ☐ | ☐ | ASTHMA | ☐ | ☐ | ARTHRITIS | ☐ | ☐ |
| CONGENITAL HEART LESIONS | ☐ | ☐ | BREATHING ISSUES | ☐ | ☐ | STROKE | ☐ | ☐ |
| HEART MURMUR | ☐ | ☐ | DIABETES | ☐ | ☐ | EPILEPSY | ☐ | ☐ |
| HIGH/LOW BLOOD PRESSURE | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ | PSYCHIATRIC TREATMENT | ☐ | ☐ |
| ANEMIA | ☐ | ☐ | HEPATITIS | ☐ | ☐ | SINUS TROUBLE | ☐ | ☐ |
| RHEUMATIC FEVER | ☐ | ☐ | JAUNDICE | ☐ | ☐ | KIDNEY TROUBLE | ☐ | ☐ |
| DRUG USE | ☐ | ☐ | ALCOHOL USE | ☐ | ☐ | IMMUNE SYSTEM DISORDER | ☐ | ☐ |
| TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS | ☐ | ☐ | OTHER: _____ | | | | | |

DATE: _____

# Oral Surgery

## MEDICAL INFORMATION, CONTINUED:

NAME OF PATIENT: _____

| | YES | NO |
|---|---|---|
| 9. HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT? | ☐ | ☐ |
| 10. IF FEMALE, ARE YOU PREGNANT? | ☐ | ☐ |
| 11. HAS YOUR PHYSICIAN RECOMMENDED PROPHYLACTIC ANTIBIOTICS PRIOR TO DENTAL TREATMENT? | ☐ | ☐ |
| 12. HAVE YOU EVER HAD ANY ARTIFICIAL JOINT PLACED? | ☐ | ☐ |
| 13. DO YOU USE OR HAVE YOU USED TOBACCO PRODUCTS? | ☐ | ☐ |
| 14. DO YOU HAVE A HISTORY OF ALCOHOL ABUSE? | ☐ | ☐ |
| 15. DO YOU HAVE ANY MEDICAL OR DENTAL PROBLEMS THAT YOU THINK WE SHOULD KNOW ABOUT? (LIST BELOW) | ☐ | ☐ |

_____

_____

SIGNATURE: _____ DATE: _____

PATIENT, PARENT OR LEGAL GUARDIAN

## FOR OFFICE USE ONLY

REVIEWED BY: _____ DATE: _____

COMMENTS: _____

_____

UPDATE: _____

_____ DATE: _____