Westchester Implant and Oral Surgery Group
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PATIENT INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Other ☐ Date

Name Gender: MALE ☐ FEMALE ☐ UNSPECIFIED ☐

Address

City/State/Zip

Home Phone # Cell #

Work# SS #

Date of Birth Age Height Weight

E-Mail Address

Emergency Contact Phone #

Referred By Phone #

Physician's Name Phone #

Preferred Pharmacy Phone #

INSURANCE INFORMATION

Subscriber/Policy Holder

Dental Insurance Company

Claims Address

Relationship to patient: ☐self ☐spouse ☐child Insured's Date of Birth

SS#/ID # Employer

- If my provider participates in the above plan, I hereby authorize and direct payment otherwise payable to me, directly to the practice. _____ initial
- I understand that my co-payment is an estimated calculation and that the quote given to me is not a guarantee of my final responsibility. Please note: We are not Medicare participating providers. _____initial

Patient Name **Date**

Reason for your visit

Has there been any change in your general health over the past year? ☐YES ☐NO

Explain

Are you under the care of a physician? ☐YES ☐NO Last Physical Exam

Have you had any serious illnesses, operations, or been hospitalized? ☐YES ☐NO

Explain

Please list any medications you are taking:

Do you take any blood thinners: ☐YES ☐NO If yes, what kind?

Are you or have you ever taken Zometa, Aredia, Fosamax, Actonel or other Bisphosphonates ☐YES ☐NO

Do you smoke? ☐YES ☐NO How Much?

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO YOU:

- ☐ Abnormal bleeding
- ☐ AIDs or HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Arthritis–painful swollen joints
- ☐ Asthma or hay fever
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Coronary insufficiency
- ☐ Coronary occlusion
- ☐ Damaged/artificial valves
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Emphysema/bronchitis
- ☐ Epilepsy/Neurological Disease
- ☐ Fainting spells/seizures
- ☐ Glaucoma
- ☐ Heart Attack; Defects, Disease; Murmur, Trouble
- ☐ Hepatitis or Liver disease
- ☐ High/Low blood pressure
- ☐ Immune system problems
- ☐ Jaw muscle/Joint problems
- ☐ Joint replacement(s)
- ☐ Kidney trouble
- ☐ Mitral Valve Prolapse
- ☐ Mental Illness
- ☐ Respiratory Problems
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Shortness of breath
- ☐ Sinus Trouble
- ☐ Stomach ulcer/ hyperacidity
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Treatment for tumor or growth
- ☐ Tuberculosis
- ☐ Wear contact lenses
- ☐ Wear dental appliances
- ☐ Other

Do you have any allergies to: ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa Drugs ☐ Antibiotics ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Latex ☐ Other

WOMEN: Are you pregnant? ☐YES ☐NO Nursing? ☐YES ☐NO Take birth control pills? ☐YES ☐NO

Bleed excessively with menstruation? ☐YES ☐NO

- I have read and answered the above questions to the best of my knowledge. I will not hold Drs. Caruso, Levarek, Ifraimova or their staff responsible for any errors or omissions that I may have made completing this form.
- I authorize the release of any medical or other information necessary to process my insurance claim &/or to discuss my treatment with my dentist, medical doctors, or insurance company.
- I authorize the release of x-rays to my dentist, family member or myself.
- I authorize Westchester Implant and Oral Surgery to perform an oral and maxillofacial exam and any images indicated for the purpose of diagnosis and treatment planning.
- I understand payment is due at the time of service. If utilizing a credit card for payment, I agree to pay a 3% non-reimbursed credit card processing fee.
- In the event of non-payment, I will bear costs of collection proceedings, not to exceed 50% of the total.
- Confirmations & correspondence are made via phone, text, and email. I permit the office to communicate with me via phone, text &/or email.
- I have read/received a copy of your notices of privacy practices, any questions have been answered.
- I am aware Drs. Caruso, Levarek and Ifraimova not Medicare Providers.
- I have read, understand, and agree with the above statements.

Date Patient Signature Parent/Legal Guardian Signature