# LAKE SHORE ORAL & MAXILLOFACIAL SURGERY
## HEALTH HISTORY QUESTIONAIRE

**Patient's Name:** **Date of Birth:** **Date:**

**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. Osteoporosis ..... Y N
   - O. 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 for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - J. Please list any and all prescription medications, diet drugs, over-the-counter mediations, 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. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **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.

**Pharmacy Information**

**A. Pharmacy Name:** _____ **B. Pharmacy Phone Number** _____

**C. Pharmacy Address/ Cross Streets** _____

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I understand that I will be given the opportunity to discuss my Health History with my Doctor.**

**Date** **Signature of Person Completing Health History** **Doctor's Initials**

**Medical Update: I have read my Health History dated _____ and confirm that it adequately states past and present conditions.**

**Date** **Exceptions or changes** **Patient's Signature** **Doctor's Initials**

# LAKESHORE ORAL & MAXILLOFACIAL SURGERY

## NEW PATIENT INFORMATION

**W**elcome to our surgical practice. We are glad you have entrusted your needs to our treatment team. Please complete this form to the best of your ability in an effort to provide you with comprehensive care. If you have any questions please ask any one our patient care coordinators who welcome the opportunity to assist. All information provided will be kept strictly confidential and according to the current Health Information Privacy Act guidelines. Your privacy and confidentiality are very important to us.

**Patient Information:**

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation:_____

Home Address: _____ City: _____Zip:_____

Email:_____

Cell Phone: _____Home Phone:_____

**Responsible Party:(Either the Subscriber to Ins or the Parent, if patient is a minor:**

Name: _____

Age: _____Date of Birth: _____Social Security#_____

Employer:_____Occupation:_____

Home Phone: _____ Alternate Phone: _____

Who may we thank for referring you to our practice? _____ Reason for visit:_____

Name of Family Dentist: _____ Last visit: _____

City: _____ Phone: _____

Name of Primary Care Physician: _____Last visit: _____ City: _____Phone:_____

**Insurance Information:**

Primary Dental Insurance:_____ SS/ID#:_____

Insured's Name: _____Relationship_____ Date of Birth:_____

Secondary Ins:_____ SS/ID#:_____

Insured's Name:_____Relationship:_____ Date of Birth:_____

**Please read carefully and initial or sign where indicated.**

I herby authorize Peter A. Krakowiak DMD APDC and/or Lakeshore Oral & Maxillofacial Surgery and any of its doctor's and/or staff to furnish information to dental/ medical insurance carriers concerning my treatment and hereby assign directly to Peter A. Krakowiak DMD APDC all payments for dental and surgical services rendered. This assignment will be required to allow the office to bill and receive payments for my care from any third party and will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I understand that it is my sole responsibility to understand my own insurance benefits and coverage. I understand and agree that payments are due on the day services are rendered. I hereby authorize Lakeshore Oral & Maxillofacial Surgery/Peter A. Krakowiak DMD APDC to release all information necessary to gain reimbursement. If the insurance fails to pay for the charges in 60 days after delivery of care I will reimburse the office directly and pursue my claim personally with my insurance carrier. I understand that any unpaid fees are subject to 18% annual interest charges, collection costs, and any additional financing costs.

**I understand that I am financially responsible for all charges whether or not paid by my Insurance/Dental Plan.** Initial_____

**I hereby acknowledge that I can request a copy of Lakeshore Oral & Maxillofacial Surgery's Notice of Privacy Practices. I understand that I have the opportunity to ask any questions regarding this Notice at any time.** Initial_____

**I consent to taking any necessary records, radiographs, and photographs of my case and permit Dr. Krakowiak and Dr. Nielsen to use these materials in professional communications, publications, and educational presentations.** Initial_____

**I understand and agree to pay a $100.00 surgical booking fee prior to scheduling a surgical appointment. I fully understand if the appointment is missed without a 36 hour notice this fee is NON-refundable.** Initial_____

I understand due to the nature of surgical therapy, differences in human constitution and response it is no way possible to warrant the outcome of any medical, surgical, dental service, or therapy. I give Dr. Krakowiak and/or Dr. Nielsen permission to perform any and all necessary treatment as he feels appropriate in the course of delivery of my surgical care. I am aware that all surgical procedures and therapy have inherent risks and complications and I will ask all questions to ensure my understanding of the treatment before commencing with any therapy.

Patient's Signature: _____ Responsible Party's Signature: _____Date: _____

LAKESHORE ORAL & MAXILLOFACIAL SURGERY
PETER A. KRAKOWIAK DMD APDC

## Notice of Billing Policy

Dear Patient,

Welcome to our practice, the entire treatment team at Lakeshore Oral & Maxillofacial Surgery is here to support you for the duration of your time with us and we truly appreciate the opportunity to work with you in achieving optimal oral health. It is our goal to provide you with excellence in clinical care and customer service. With that, our office will bill your dental insurance in an effort to maximize your benefits for the specialized care we provide. We cannot, however, **guarantee** that your insurance company will cover all or a portion of your treatment. Please note that all fees associated with your treatment are your responsibility in the event your insurance does not cover the cost of treatment. Your insurance company has 60 days to pay a claim on your behalf. If there is a remaining balance on your account you will be notified accordingly and payment is due at that time for all unpaid claims. If you have any questions regarding our policies or procedures please do not hesitate to contact our billing administrator. In addition, if you have general questions regarding your insurance coverage any one of our qualified patient care coordinators welcome the opportunity to help.

Thank you,

Lakeshore Oral & Maxillofacial Surgery

## Acknowledgment of Medicare Opt-Out

By signing below, I fully acknowledge and understand that Lakeshore Oral and Maxillofacial Surgery has opted out of all Medicare programs, and that I can not submit (or request that my the practice submit) a claim to Medicare or its agents for any services provided by Lakeshore Oral and Maxillofacial Surgery, even if such services would otherwise be covered.

I understand that I have the right to have services provided by other oral and maxillofacial surgeons or other practitioners for whom Medicare payment would be made.

I understand that Lakeshore Oral and Maxillofacial Surgery is not excluded from participation in the Medicare program under Section 1128 of the Social Security Act or pursuant to any other legal authority.

Patient Name: _____Date:_____

Signature:_____

**LAKESHORE ORAL & MAXILLOFACIAL SURGERY**

PETER A. KRAKOWIAK DMD APDC

# Authorization to Release Health Care Information

I,_____authorize the above listed doctor and practice, to release any

necessary health care information for to the following:

1. Name: _____Relationship:_____

   Phone Number: _____

2. Name:_____Relationship:_____

   Phone Number: _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called “Revocation of Authorization for Use and Disclosure of Health Care Information” or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient’s authorized representative Date signed

_____

**Relationship or status if signed by parent, legal guardian, personal representative, etc.**

LAKESHORE ORAL & MAXILLOFACIAL SURGERY
PETER A. KRAKOWIAK DMD APDC

# Acknowledgment of Receipt of Notice of Privacy Practices

*You May Refuse to Sign This Acknowledgement.*

I,_____[full name], am aware of Lakeshore Oral & Maxillofacial Surgery's Notice of Privacy Practices, and understand that I may request a copy at any time.

**Print Name** :_____

**Signature:**_____

**Date:**_____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the Following:

**Personal Representative's name:** _____

**Relationship to Patient:**_____

## For Office Use Only

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)_____