William L. Cecere III, DDS, MD

ORAL AND MAXILLOFACIAL SURGERY

New Patient Paperwork

Today's Date _____

Name _____ Birthdate ____ / ____ / ____ Home Phone _____

Address _____Apt #_____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Drivers License # _____

Please Check: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Name of Person to Contact in Case of an Emergency_____ Phone #_____

Responsible Party (Other than yourself)

Name of Person Responsible: _____ Relationship to Patient _____

Address _____ Apt # ____ City _____ State _____ Zip _____

Home phone_____ Birthdate _____ / _____ / _____

Employer _____ Work Phone _____ Ext. _____ Social Security # _____ - _____ - _____

Dental Insurance Information

Name of Person Responsible for this Account _____ Relationship to Patient _____

Birthdate _____ / _____ / _____ Social Security # _____ - ____ - _____

Name of Employer _____ Union or Local # _____ Work Phone _____ Ext. _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Medical Insurance Information

Name of Person Responsible for this Account _____ Relationship to Patient _____

Birthdate _____ / _____ / _____ Social Security # _____ - ____ - _____

Name of Employer _____ Union or Local # _____ Work Phone _____ Ext. _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Additional Coverage

Do you have any additional coverage? ◯ Yes ◯ No *If Yes, please ask the receptionist for secondary insurance sheet.*

Referral

We are proud to welcome new patients to our office and would like to know who referred you? _____

Physician _____ Dentist _____ Friend/Relative _____ Yellow Pages _____ Other _____

Name of Dentist _____ Name of Medical Doctor _____

Please complete the opposite side of the page. Thank you.

Patient Medical History

Height _____ Weight _____ Sex _____

Do you have or ever had any of the following (please check only those that apply – leave others blank):

- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Heart Valve Problem
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Epilepsy, Seizures
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ Bleeding Disorder
- ☐ Hepatitis, Liver Disease
- ☐ Tuberculosis, Lung Disease
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Kidney Disease
- ☐ Thyroid or other Gland Disease
- ☐ Ulcers
- ☐ Arthritis
- ☐ Stroke
- ☐ Malignancy, (Cancer)
- ☐ Mental Illness
- ☐ Nerve/Muscle Disease
- ☐ TMJ Problems
- ☐ Facial Fractures
- ☐ Venereal Disease
- ☐ Stomach/Intestine Disease

Any other health problems? _____

Have you ever had surgery? _____ When? _____For? _____

Were you ever hospitalized for anything else? _____ What? _____ When? _____

Have you ever had general anesthetic? _____ When? _____ Any problems? _____

Have you ever had any pins, rods, plastic joints, shunts or valves permanently inserted into your body? _____

Are you pregnant? _____ Are you nursing? _____ Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____ How often? _____

Do you have any pain or discomfort in your mouth at this time? _____ Do you feel nervous about having dental treatment? _____

Medications

Are you taking any of the following medications for Osteoporosis or Bone metastases:

☐ Fosamax ☐ Actonel ☐ Boniva ☐ Aredia ☐ Zometa

Are you on, or have you recently taken any drug or medication? ◯ Yes ◯ No

If yes, please list them: _____

_____

Allergies

Are you A**llergic** to: ☐ Aspirin ☐ Penicillan ☐ Codeine

Do you have any other allergies? _____

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Cecere to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such surgical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Cecere insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I may be charged a 1.5% per month if my balance goes beyond 30 days.

X _____

Signature of patient (or parent if minor)

Doctors Signature _____ *Date* _____

Email This Form

Print This Form

Save This Form