DRS. GARFIELD, KRAMER, D'ABUNDO and SOH

Practice Limited to
Oral and Maxillofacial Surgery

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I HAVE READ AND UNDERSTAND ALL HIPAA REGULATIONS

Name ____ Date ____________________
(Last) (First)

All the information listed will be kept strictly confidential.

Question	Yes	No
1. Are you in a good state of health? If not; why? ____________	Yes ☐	No ☐
2. Who is your family physician? ____________ When was last visit? ____________		
3. Are you taking any medications? (Including birth control pills) If yes; which medications and for what conditions? ____________	Yes ☐	No ☐
4. Do you have high blood pressure? If yes; how is it being treated? ____________	Yes ☐	No ☐
5. Have you ever had Rheumatic Fever?	Yes ☐	No ☐
6. Do you have a Heart Murmur?	Yes ☐	No ☐
7. Have you ever had any heart trouble? Mitral Valve Prolapse? If yes; please be specific. ____________	Yes ☐	No ☐
8. Do you have diabetes? If yes; how is it controlled? ____________	Yes ☐	No ☐
9. Do you have asthma? If yes; date of last attack ____________, frequency of attacks ____________, Was it necessary to bring patient to physician? ____________.	Yes ☐	No ☐
10. Have you ever had a seizure? If yes; what medications do you take to control them? ____________	Yes ☐	No ☐
11. Do you have kidney trouble?	Yes ☐	No ☐
12. Do you have thyroid trouble?	Yes ☐	No ☐
13. Do you have liver trouble?	Yes ☐	No ☐
14. Have you ever had a stomach or intestinal ulcer?	Yes ☐	No ☐
15. Have you ever had hepatitis?	Yes ☐	No ☐
16. Do you have glaucoma?	Yes ☐	No ☐
17. Do you have trouble breathing?	Yes ☐	No ☐
18. Have you ever been hospitalized for anything other than pregnancy? If yes; what? ____________	Yes ☐	No ☐
19. Are you allergic to any substances?	Yes ☐	No ☐
20. Did you ever have a reaction from any drug (local anesthesia, general anesthesia, aspirin, pain killers, penicillin, etc)?	Yes ☐	No ☐
21. Do you bleed excessively?	Yes ☐	No ☐
22. Females of child bearing age: Are you pregnant?	Yes ☐	No ☐
23. Have you ever had a problem with a general anesthetic?	Yes ☐	No ☐
24. Have you ever had a problem with a local anesthetic?	Yes ☐	No ☐
25. Do you have AIDS or have you tested HIV positive? (Optional)	Yes ☐	No ☐
26. Have you had any joint replacements?	Yes ☐	No ☐
27. Do you have any other information the doctor should know?	Yes ☐	No ☐
If yes, what is that information?	Yes ☐	No ☐

I AM SIGNING THIS MEDICAL HISTORY TO ATTEST THAT I HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY ABILITY, AND THAT THE DOCTOR HAS EXPLAINED ANY QUESTIONS WHICH I DO NOT UNDERSTAND.

I recognize that any of the fees charged to me by you for your services are primarily my responsibility despite any medical or union coverage. Should the union or medical insurance fail to pay you, I understand that I will be personally responsible for the payment of those fees. I further understand that should I fail to pay any fees due to your office and you refer my account to an attorney, I will pay a lawyers fee equal to 20% of the balance due plus court costs.

I understand that if I do not abide by the terms and conditions of the payment requirements concerning fees for services billed to me that I will be charged 1.5% interest per month on any outstanding unpaid balance.

Signature ____