Canyon County Oral & Maxillofacial Surgery

Nicholas A Massoth, DMD

PATIENT INFORMATION

Patient's last name: First: Middle:	Birth date:	Driver Name & Phone #:	
Home Phone #: | Work #:	Cell #:	Age:	Sex: ☐ Male ☐ Female
Street address:	SS#:	Referring Dentist	
City: | State:	ZIP CODE:	Personal Physician:	
Emergency Contact Person: | Relationship to patient:	Home phone #:	Work or cell:	

INSURANCE INFORMATION

PERSON with Financial Responsibility:	Address:	Birth Date:	Phone #'s:	
Company Name: (if work-related ins)	Company Address and Phone #:		Relationship of Patient to Subscriber: Self: ☐ Spouse: ☐ Child: ☐ Other: ☐	
PRIMARY Insurance Co: ☐ Dental or ☐ Medical	Subscriber's name:	Policy #	Group #	Birth Date:
2ndry Insurance Co: ☐ Dental or ☐ Medical	Subscriber's name:	Policy #	Group #	Birth Date:

HEALTH HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree:

☐ Heart Trouble, Heart Murmur	☐ Cancer	☐ Previous Surgeries
☐ High Blood Pressure	☐ Diabetes	☐ Prosthetic Joints
☐ Chest Pains or Shortness of Breath	☐ Thyroid	☐ Osteoporosis
☐ Excessive Bleeding, Bleeding Disorder	☐ Glaucoma	☐ - Ever taken Actonel?
☐ Asthma, or Lung Disease	☐ Kidney or Liver Problems	☐ - Ever taken Zometa?
☐ Smoke or Use Smokeless Tobacco	☐ Hepatitis C or HIV	☐ Allergic to:
☐ Stroke or Seizure	☐ Possible Pregnancy	

Current Medications: (Please list here or on back of this page.)

Have you had anything to eat or drink (including water) since midnight if you are scheduled for surgery? Very Important! ☐ YES ☐ NO

INSURANCE ASSIGNMENT AND CONSENTS

- I give consent for clinical photographs for educaton, training, and patient record purposes? ☐ YES ☐ NO
- I authorize my insurance benefits be paid directly to the physican. I understand that I am financially responsible for any balance. I also authorize Canyon County Oral & Maxillofacial Surgery or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*