TRINITY RIVER
ORAL SURGERY
& DENTAL IMPLANT CENTER

Todd A. Kovach, DDS, MD
Board-Certified Oral and Maxillofacial Surgeon

Patient Information

Patient's Name: _____ Date: _____

Age: _____ DOB: _____ Soc. Sec. #: _____ Driver's License: _____

Address: City: State: _____ Zip: _____

☐ Home: _____ ☐ Mobile: _____ ☐ Work: _____ (Check preferred phone contact)

Email: _____

Employer, or School if Student: _____

Occupation: _____

Who is your General Dentist? _____ Orthodontist? _____

Primary Care Physician? _____

How did you hear about us? _____

Preferred Pharmacy? _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship to Patient: _____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____

DOB: _____ Soc. Sec. #: _____ Driver's License: _____

Primary Phone: Secondary Phone: Email: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Dental Insurance: _____

Insurance Address: _____

Policyholder Name: _____ S.S. #: _____ DOB: _____

Relationship to Patient: Insurance Phone: _____

Policy #: _____ Group #: _____

Medical Insurance: _____

Insurance Address: _____

Policyholder Name: _____ S.S. #: _____ DOB: _____

Relationship to Patient: Insurance Phone: _____

Policy #: _____ Group #: _____

TRINITY RIVER ORAL SURGERY & DENTAL IMPLANT CENTER

Medical History

Name: _____

Height: _____ **Weight:** _____

Reason for your visit: _____

- Are you in good health? ..... ☐ Yes ☐ No
- Have there been any changes in your health in the past year? ..... ☐ Yes ☐ No
- Have you had any adverse effects from dental treatment? ..... ☐ Yes ☐ No

  Please describe: _____

***Please check if you have or have ever had any of the following.**

YES	NO		If Yes, When?
☐	☐	Congenital Heart Defect	
☐	☐	Heart Valve Disorder or Replacement	
☐	☐	Heart Murmur	
☐	☐	Coronary Artery Disease/Stents	
☐	☐	History of Heart Attack	
☐	☐	High Blood Pressure	
☐	☐	Atrial Fibrillation	
☐	☐	Irregular Heart Beat	
☐	☐	Stroke or TIA	
☐	☐	Seasonal Allergies	
☐	☐	Asthma	
		How often do you require a rescue inhaler?	
		Does aspirin or ibuprofen make your asthma worse?	
		Ever hospitalized for asthma?	
☐	☐	COPD	
☐	☐	Other Lung Disease	
☐	☐	Bleeding Disorder	
☐	☐	Kidney Disease	
☐	☐	Diabetes	
☐	☐	Thyroid Disease	
☐	☐	Osteoporosis	
☐	☐	Osteoarthritis	
☐	☐	Total Joint Replacement (Hip/Knee)	
☐	☐	Rheumatoid Arthritis	
☐	☐	Other Autoimmune Disease	

YES	NO		If Yes, When?
☐	☐	Liver Disease	
☐	☐	Stomach or Intestinal Ulcers	
☐	☐	Reflux Disease	
☐	☐	Sleep Apnea	
		Do you use a CPAP?	
☐	☐	History of Cancer	
☐	☐	History of Chemotherapy	
☐	☐	Radiation for Cancer	
☐	☐	Glaucoma	
☐	☐	Seizure Disorder	
☐	☐	Anxiety	
☐	☐	Depression	
☐	☐	Psychiatric Conditions	
☐	☐	History of Drug or Alcohol Abuse	
☐	☐	Smoke or Chew Tobacco	
		How much per day?	
☐	☐	Marijuana	
☐	☐	Street Drugs	
☐	☐	Drink Alcohol	
		How much per week?	
☐	☐	Pregnant	
☐	☐	Nursing	
☐	☐	Nausea / Vomitting After Surgery	
☐	☐	Problems with Anesthesia	
☐	☐	Family History of Anesthesia Complications	

☐ ☐ Do you have any condition the doctor should know about? If so, please describe_____

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Medical History

Name: _____

RECENT SYMPTOMS: Please check if you have any recent symptoms of the following:

- ☐ Fainting / Dizziness
- ☐ Angina / Chest Pain
- ☐ Shortness of Breath
- ☐ Fever
- ☐ Chills
- ☐ Clicking / Pain in Jaw Joints
- ☐ Clenching / Grinding Teeth
- ☐ Snoring
- ☐ Palpitations / Racing Heart

MEDICATIONS: Please check if you have ever taken or are taking any of the following:

- ☐ Blood Thinners (Coumadin, Plavix, Pradaxa, Aspirin, Vitamin E, Ginkgo Biloba, Fish Oil)
- ☐ Sedatives, Sleeping Pills, or Anxiety Medication (Valium, Ambien, Clonazepam)
- ☐ Bone Density Medications for Osteoporosis (Fosamax, Boniva, Actonel, Prolia, Reclast)
- ☐ Bone Density Medications for Cancer (Zometa, Aredia, Xgeva/Denosumab)
- ☐ Medications That Suppress Your Immune System (Humira, Cyclosporine, Methotrexate)
- ☐ Steroids
- ☐ Birth Control (Antibiotics may decrease the effectiveness of oral contraceptives)
- ☐ Insulin

Please list all current medications, including non-prescription and herbal or homeopathic remedies:

_____

_____

_____

☐ **ALLERGIES:** Are you allergic or have you had a bad reaction to:

- ☐ No Known Allergies
- ☐ Cephalosporins/Keflex
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Latex
- ☐ Soy
- ☐ Eggs
- ☐ Sulfites
- ☐ Local Anesthetic (Lidocaine)
- ☐ Penicillin

Please list any other allergies or reactions:

_____

_____

_____

SURGICAL HISTORY: Please list any previous surgeries, major illnesses, or hospitalizations:

_____

_____

_____

HEALTH HISTORY

I certify that I have read and understand the questions regarding my medical history. I will have the opportunity to discuss my health history with my surgeon in detail prior to surgery. I will not hold my surgeon or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient or Guardian Signature: _____ **Date:** _____

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Authorization/Signature

Patient's Name: _____

AUTHORIZATION

I authorize my surgeon and his designated staff to perform an examination for the purpose of diagnosis and treatment planning. This includes the taking of all x-rays required as a necessary part for the examination. In addition, I authorize the release of any information necessary for consultation with my other dentists or physicians, or to process insurance claims.

FEES AND PAYMENTS

Thank you for choosing Trinity River Oral Surgery & Dental Implant Center. We will make every effort to provide you with the finest care and convenient financial options. You may help keep costs of care low by making payment at the conclusion of your consultation and prior to your surgical procedure. If applicable, please provide our office with a copy of your dental and medical insurance cards prior to your consultation. We are happy to verify insurance for you and obtain an estimate on your behalf. Unfortunately, insurance companies do not guarantee payment, even with pre-determined benefits. The patient is responsible for any deductible, co-payments, or any balance not paid by your insurance company.

I understand I am responsible for all fees not paid by insurance, and I hereby authorize insurance payments directly to Trinity River Oral Surgery & Dental Implant Center.

☐ ## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

We fully support your right to privacy of health information, and we take extensive measures to secure the privacy of your protected health information. A complete description of how your medical information will be used and disclosed by Trinity River Oral Surgery & Dental Implant Center is in our Notice of Privacy Practices, which you may read before signing this Acknowledgment. This Notice is available in our office and our website, and you will be given a copy for your personal use upon request.

Patient or Guardian Signature: _____ **Date:** _____