



Queensboro Oral Surgery Associates

Oral, Maxillofacial & Implant Surgery - Dr. Sanford M. Blecker/ Dr. Howard A. Ochs

(Mr. Mrs. Miss. Dr.) Patient's Name _____ Date _____

Street Address _____ City _____ State _____ Zip _____

Phone Number (Home) _____ (Bus.) _____ Social Sec. # _____

Date of Birth _____ Occupation/School _____

Dentist Name _____ Referred By (If other than dentist) _____

If patient is a minor, parent or guardians name _____

Chief Complaint: What is the reason for this visit? _____

Medical History

Do you have or have you had any of the following diseases or problems? Answer all questions, circle Y or N.

Cough, Cold or Flu	Y N	Heart Murmur	Y N	Cancer	Y N	Glaucoma	Y N
Asthma	Y N	Angina	Y N	Chemotherapy	Y N	Diabetes	Y N
Bronchitis	Y N	Irregular Heart Beat	Y N	Stroke	Y N	Artificial Joints	Y N
Sinusitis	Y N	Pacemaker	Y N	Liver Disease	Y N	Blood Transfusions	Y N
Emphysema	Y N	Artificial Heart Valve	Y N	Kidney Disease	Y N	Blood Disease	Y N
Lung Disease	Y N	Rheumatic Fever	Y N	Thyroid Disease	Y N	Immunosuppressive	
Shortness of Breath	Y N	High Blood Pressure	Y N	Hepatitis	Y N	Disorder	Y N
Heart Disease	Y N	Seizures	Y N	Ulcers	Y N	Drug/Alcohol Abuse	Y N

Any other serious medical conditions? _____

As far as you know, do you require any premedication prior to any dental treatment or surgery? _____

Do you have a tendency to bleed, bruise or swell easily? _____

Are you taking any type of medication? List: _____

Do you have any allergies or adverse reactions to any medications? List: _____

Are you presently under the care of a physician and for what reason? _____

Have you undergone a recent operation? Do you smoke? Wear contact lenses?

Woman: If pregnant, what month? _____ Taking birth control pills? _____

For anesthesia patients:

What time did you last eat or drink? _____

Have you had any complications or unfavorable reactions? _____

Patient Signature _____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

We are happy to accept insurance assignment, but a deposit for the amount not covered must be paid on day of service.

Dental: Primary Insurer _____ Secondary Insurer _____

Medical: Primary Insurer _____ Policyholder _____ ID# _____ Group# _____ Cat _____

Medical: Secondary Insurer _____ Policyholder _____ ID# _____ Group# _____ Cat _____

Medicare# _____ Medicaid # _____ US Healthcare # _____

Please make financial arrangements with receptionist prior to surgery.

Person financially responsible for this account if other than patient _____ Relationship to patient _____

Mailing address if different from above _____

Method of Payment: Cash Check MasterCard Visa American Express Diners Insurance

For Assignable Dental/Medical Plans Including Medicare:

I, the undersigned, have insurance coverage with _____ and assign directly to the doctor any benefits otherwise payable to me for services rendered. I will be responsible for any payment that my insurance doesn't cover up to the prearranged fee. I also understand that my signature authorizes the release of any insurance information necessary to file this claim.

Signature _____ Date _____