EDISTO ORAL SURGERY

Eric Olendorf, DDS • Board-Certified Oral Surgeon

1175 Cook Road, Suite 125
Orangeburg, SC 29118
p: (803) 534-5444 f: (803) 531-3668

All sections must be completed in full Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date (MM/DD/YY): _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Social Security #: _____ Driver's License #: _____

General Dentist: _____ Referring Doctor: _____

Pharmacy: _____ Pharmacy Address: _____

Emergency Contact: _____ Phone: _____

Guardian Name (patients under the age of 18): _____

Birth Date (MM/DD/YY): _____ Relationship: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

☐ Self (skip this section) ☐ Spouse ☐ Father ☐ Mother Other: _____

First Name: _____ Last Name: _____

Birth Date (MM/DD/YY): _____ S.S. #: _____

DENTAL INSURANCE INFORMATION

Name of Primary Dental Insurance: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group #: _____

Name of Employer: _____

Relationship to Policy Holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse Other: _____

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Patient Name: _____ Date: _____

HIPAA NOTICE (AUTHORIZATION TO RELEASE INFORMATION)

We are committed to protecting your privacy. We do not release your medical or personal information outside of your provider and insurance networks without written permission.

If you would like us to share your appointment details or health information with others, please list them below:

Authorized Individual(s):

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

FEES & PAYMENTS

We make every effort to keep down the cost of your care. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the surgeon and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You will be responsible for all collection costs, attorney's fees, and court costs.

MEDICARE NOTICE (NON-PARTICIPATION)

Our providers have chosen not to be participating providers with Medicare. As such:

- We cannot file Medicare claims on your behalf.
- You may not submit claims to Medicare for services provided in this office.
- You will be responsible for payment in full at the time of service.
- You will accept full financial responsibility for services rendered.

> **I hereby acknowledge that I have read, understood, and received a copy of (or had access to) the above policies, including the Notice of Privacy Practices, Fees & Payments Policy, and Medicare Notice (Non-Participation). I further certify that the information I have provided is true and accurate to the best of my knowledge.**

_____ _____

Patient / Guardian Signature Date

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HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems you may have, or medications you may be taking, could have an important interrelationship with the care you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Patient Name: _____ Height: _____ Weight: _____

Reason for today's office visit: _____

	Y	N	*If yes, please explain*
1. Are you in good health?	☐	☐	
2. Have there been any changes in your general health in the past year?	☐	☐	
3. Are you under the care of a physician?	☐	☐	
4. Have you had any illness, operation, or been hospitalized in the past five years?	☐	☐	
5. Do you have unhealed / recurrent injuries, inflamed areas, growths, or sore spots in or around your mouth?	☐	☐	
6. Do you have a prosthetic joint / implant?	☐	☐	
7. Have you had a heart valve replacement or vascular graft?	☐	☐	
8. Have you ever had general anesthesia or IV sedation?	☐	☐	
9. Have you, or a family member, had unusual or serious reactions to anesthesia or IV sedation?	☐	☐	
10. Has a physician or dentist recommended antibiotics prior to your dental treatment?	☐	☐	

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE:

	Y	N		Y	N
11. Rheumatic fever?	☐	☐	**42.** Thyroid trouble?	☐	☐
12. Damaged heart valves / mitral valve prolapse?	☐	☐	**43.** Diabetes?	☐	☐
13. Heart murmur?	☐	☐	**44.** Low blood sugar?	☐	☐
14. High blood pressure?	☐	☐	**45.** Kidney trouble?	☐	☐
15. Low blood pressure?	☐	☐	**46.** High cholesterol?	☐	☐
16. Chest pain / angina?	☐	☐	**47.** Are you on dialysis?	☐	☐
17. Heart attack(s)?	☐	☐	**48.** Swollen ankles / arthritis / joint disease?	☐	☐
18. Irregular heart beat?	☐	☐	**49.** Osteoporosis / osteopenia?	☐	☐
19. Cardiac pacemaker?	☐	☐	**50.** Osteonecrosis?	☐	☐
20. Heart surgery?	☐	☐	**51.** Stomach ulcer / acid reflux?	☐	☐
21. Pneumonia, bronchitis, chronic cough?	☐	☐	**52.** COVID-19?	☐	☐
22. Asthma?	☐	☐	**53.** Contagious diseases?	☐	☐
23. Hay fever / sinus problems?	☐	☐	**54.** Sexually transmitted diseases?	☐	☐
24. Snoring?	☐	☐	**55.** Problems with immune system?	☐	☐
25. Sleep apnea / CPAP?	☐	☐	**56.** Autoimmune disease?	☐	☐
26. Difficult breathing / other lung trouble?	☐	☐	**57.** Delay in healing?	☐	☐

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	Y	N		Y	N
27. Tuberculosis?	☐	☐	**58.** A tumor or growth?	☐	☐
28. Emphysema?	☐	☐	**59.** Cancer / radiation therapy / chemotherapy?	☐	☐
29. Do you smoke or vape?	☐	☐	**60.** Chronic fatigue / night sweats?	☐	☐
30. Do you use chewing tobacco?	☐	☐	**61.** Are you on a diet?	☐	☐
31. Alcohol intake?	☐	☐	**62.** History / treatment for alcohol use disorder?	☐	☐
32. Blood transfusion?	☐	☐	**63.** History / treatment for marijuana or substance use disorder?	☐	☐
33. Blood disorder such as anemia?	☐	☐	**64.** Contact lenses?	☐	☐
34. Bruise easily?	☐	☐	**65.** Eye disease / glaucoma?	☐	☐
35. Bleeding tendency / abnormal bleed?	☐	☐	**66.** Mental health problems / anxiety / depression?	☐	☐
36. Hepatitis, jaundice, or liver disease?	☐	☐	**67.** A removable dental appliance?	☐	☐
37. Infectious mononucleosis?	☐	☐	**68.** Pain or clicking of jaws when eating?	☐	☐
38. Gallbladder trouble?	☐	☐	**WOMEN ONLY:**		
39. Fainting spells?	☐	☐	**69.** Is there a possibility of pregnancy?	☐	☐
40. Convulsions / epilepsy?	☐	☐	**70.** Expected delivery date:		
41. Stroke?	☐	☐	**71.** Are you nursing?	☐	☐
			72. Are you taking birth control pills?	☐	☐

Note: Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist regarding other methods of birth control.

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HEALTH HISTORY (continued)

ARE YOU NOW TAKING:

	Y	N	*If yes, please explain*
73. Any kind of medication, drug, or pills?	☐	☐	
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginkgo biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?	☐	☐	
75. Diet pills, incl. GLP-1's for diabetes/weight loss (Trulicity, Ozempic, Byetta, Victoza, Rybelsus, Mounjaro, Wegovy, Saxenda)?	☐	☐	
76. Any natural product, herbal supplement, or homeopathic remedy?	☐	☐	
77. Bone density meds / RANKL inhibitors / bisphosphonates (Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, Evista) in the past 12 yrs?	☐	☐	
78. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis?	☐	☐	

79. If under a physician's care for pain management, or recovering from drug addiction, please select the medication you are currently taking:

☐ Methadone ☐ Suboxone ☐ Oxycodone ☐ Fentanyl Other: _____

Treating doctor: _____

80. Please list any medications you are currently taking:

Medication	**Dosage**	**Frequency**

ADDITIONAL INFORMATION

Is there any condition concerning your health the Doctor should be told about? ☐ Yes ☐ No

If yes, describe: _____

Do you wish to speak to the Doctor privately about anything? ☐ Yes ☐ No

Is this visit related to an accident? ☐ Yes ☐ No

If yes, type: ☐ Automobile ☐ Work related ☐ Other

Date of injury: _____ Insurance co. handling claim: _____

Claim number: _____ Attorney/adjustor: _____

Telephone number: _____

Family history of: ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems

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ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO:

	Y	N		Y	N
81. Local anesthetic (numbing meds.)?	☐	☐	**88.** Codeine or other narcotics?	☐	☐
82. Penicillin?	☐	☐	**89.** Latex?	☐	☐
83. Other antibiotics?	☐	☐	**90.** Soy?	☐	☐
84. Sulfa drugs?	☐	☐	**91.** Eggs / yolk?	☐	☐
85. Sodium pentothal / Valium / other tranquilizers?	☐	☐	**92.** Sulfites?	☐	☐
86. Aspirin?	☐	☐	**93.** Do you have any known allergies?	☐	☐
87. Amoxicillin?	☐	☐			

94. Please list any allergies other than drug allergies: _____

95. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name: _____

Medication / Antibiotic Name: _____

_____ _____

Patient / Guardian Signature Date