FLINT
oral & maxillofacial surgery
Derrick D. Flint, DDS, MD A Board Certified Oral & Maxillofacial Surgeon
(512) 838-3118 www.flintoms.com 5301 Davis Ln, Suite 102, Austin, TX 78749

Patient Registration

Responsible Party (If different from patient)

First Name:_____Last Name:_____Middle Init:_____

Street Address:_____

City, State, Zip:_____

Home Phone:_____Cell Phone:_____Work:_____

Birth Date:_____SSN:_____Driver's Licence:_____

Patient Information

First Name:_____Last Name:_____Middle Init:_____

Street Address:_____

City, State, Zip:_____

Home Phone:_____Cell Phone:_____Work:_____

Date of Birth:_____SSN:_____Email:_____

Sex: O MaleO Female Marital Satus: O Married O Single O Divorced O Widowed

Employment Status: O Full Time O Part Time O Retired O Student

Person to contact in case of an emergency:_____Phone:_____

Primary Dentist:_____Phone Number:_____

Who may we thank for referring you to our office:_____

Insurance Information

Name of Insured:_____Relationship to Insured:_____

Insured Birthdate:_____Insured SSN:_____Employer:_____

Name of Insurance Company: _____Phone Number:_____

Member ID Number_____Group Number_____

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
   Physician's Name _____
   Address _____
   _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N
   _____
   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? .. Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? . Y N
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax ,Actonel or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____
     _____
     _____
     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N
     _____
     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **is there any chance** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

FLINT
oral & maxillofacial surgery
Derrick D. Flint, DDS, MD A Board Certified Oral & Maxillofacial Surgeon
(512) 838-3118 www.flintoms.com 5301 Davis Ln, Suite 102, Austin, TX 78749

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

Home Telephone _____

O.K. to leave message with detailed information
Leave message with call-back number only

Written Communication

O.K. to mail to my home address
O.K. to mail to my work/office address
O.K. to fax to number indicated
O.K. to text to cell phone

Work Telephone _____

O.K. to leave message with detailed information
Leave message with call-back number only

Other (Fax/Cell, etc.) _____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

Spouse
Parent
Child
Other (specify): _____
None

_____ _____
Patient Signature Date

_____ _____
Print Name Birth date

FLINT
oral & maxillofacial surgery
Derrick D. Flint, DDS, MD A Board Certified Oral & Maxillofacial Surgeon
(512) 838-3118 www.flintoms.com 5301 Davis Ln. Suite 102, Austin, TX 78749

Acknowledgement of Patient Responsibility

Fees for treatment are due at the time of service. I understand that my insurance will be billed as a courtesy, and it is my responsibility to know and understand the exclusions and limitations of my dental insurance policy. Should my insurance change, I understand that it is my responsibility to inform Flint OMS with this information.

I understand that fees given are only an estimate and agree to pay all fees (co-pays and deductibles) in full, as well as any portion not covered by my insurance company for ANY reason.

_____
Patient Name

_____
Print Name (Responsible party)

_____
Signature (Responsible party)

_____
Date

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	Yes No	Yes No
Are you/they having shortness of breath or other difficulties breathing?	Yes No	Yes No
Do you/they have a cough?	Yes No	Yes No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes No	Yes No
Have you/they experienced recent loss of taste or smell?	Yes No	Yes No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	Yes No	Yes No
Is your/their age over 60?	Yes No	Yes No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes No	Yes No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes No	Yes No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.