ANDREW ARANGO
ORAL & FACIAL SURGERY

info@aaoralsurgery.com
214.888.3234 phone
214.888.3235 fax
aaoralsurgery.com

Hillcrest Crossing
8611 Hillcrest Rd.
Suite 235
Dallas, Texas 75225

Name:_____ **Date:** _____

MEDICATIONS

Are you taking or have you ever taken any of the following medications?	**YES**	**NO**
BISPHOSPHONATES (used to treat osteoporosis or breast cancer) for example: Boniva, Fosamax, Actonel, Zometa, Xgeva, Prolia, or other bisphosphonate	____	____
ANTICOAGULANTS for example: Coumadin, Warfarin, Aspirin, Plavix, Xarelto, or any other anticoagulant	____	____
WEIGHT LOSS MEDICATIONS (otherwise known as GLP-1 AGONISTS) for example: Ozempic, Mounjaro, Wegovy, or any other weight loss medication	____	____

Primary Care Physician/ Internist Name: _____ Phone #: (_____) _____ - _____

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING:

	Name of Drug	Strength	Times per Day
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

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HEALTH HISTORY FORM

PLEASE ANSWER ALL QUESTIONS BY MARKING YES (Y) OR NO (N)

		Y	N
1.	Are you in good health?	☐	☐
2.	Has there been any change in your general health in the past year?	☐	☐
3.	Date of last physical exam: _____		
4.	Are you now under a physician's care for a particular problem?	☐	☐
5.	Have you ever had any serious illnesses, operation or hospitalizations?	☐	☐
	If yes, please describe: _____		
6.	Height: _____ Weight: _____		

7. DO YOU HAVE OR HAVE YOU EVER HAD:

	Y	N
Rheumatic Fever or Rheumatic Heart Disease	☐	☐
Congenital Heart Disease	☐	☐
Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)	☐	☐
Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)	☐	☐
Seizures, Convulsions, Epilepsy, Fainting, or Dizziness	☐	☐
Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion, or Easy Bruising	☐	☐
Liver Disease (Jaundice, Hepatitis)	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Arthritis	☐	☐
Stomach Ulcers or Colitis	☐	☐
Radiation (X-ray) Treatment for Cancer	☐	☐
Jaw Joint Clicking/Popping, Pain Near Ear, Difficulty Opening Mouth, Grinding or Clenching Teeth	☐	☐
Sinus or Nasal Problems	☐	☐
Any condition, drug, or transplant that has depressed your immune system	☐	☐

8. ARE YOU USING ANY OF THE FOLLOWING:

	Y	N
Antibiotics	☐	☐
Anticoagulants (Blood Thinners)	☐	☐
Aspirin or drugs such as Motrin, Aleve, Ibuprofen	☐	☐
High Blood Pressure Medications	☐	☐
Steroids (Cortisone, etc.)	☐	☐
Tranquilizers	☐	☐
Insulin or Oral Anti-Diabetic Drugs	☐	☐
Digitalis, Inderal, Nitroglycerin, or other heart drugs	☐	☐

Are you presently taking or have you ever taken any of the following **Bisphosphonate Medications:** Y ☐ N ☐
Etidronate (Didronel) • Tiludronate (Skelid) • Alendronate (Fosamax) • Risedronate (Actonel) • Ibandronate (Boniva) • Pamidronate (Aredia) • Zoledronate (Zometa) • Zoledronic Acid (Reclast)

Please list any and ALL medications (prescription, OTC, herbal or holistic, vitamins, minerals):

_____

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9. ALLERGIES OR ADVERSE REACTIONS:

	Y	N
Local Anesthesia (Novocain, etc.).....	☐	☐
Penicillin or other antibiotics.....	☐	☐
Sedatives or Barbiturates.....	☐	☐
Aspirin or Ibuprofen.....	☐	☐
Codeine or other pain killers.....	☐	☐
Latex or Rubber Products.....	☐	☐

Other allergies/reactions (Please list):

_____

10. FOR WOMEN ONLY

	Y	N
Pregnant or possibly pregnant?.....	☐	☐
Nursing?.....	☐	☐

If using oral contraceptives, antibiotics and some medications may reduce effectiveness. Use mechanical birth control for one full cycle after completing medication. Consult your physician for guidance.

11. Do you smoke or chew tobacco? Y ☐ N ☐ How much per day? _____

12. Past history of alcohol/chemical dependency or emotional disorder affecting care? Y ☐ N ☐

13. Serious problems with previous dental treatment? Y ☐ N ☐

14. Any family or personal problems with IV anesthesia? Y ☐ N ☐

15. Any other disease or condition the doctor should know about?

16. Do you wish to speak with the doctor privately? Y ☐ N ☐

I certify that the information provided in this Health History Form is complete and accurate to the best of my knowledge. I understand that withholding or providing incorrect information may result in improper diagnosis or treatment. I authorize the oral surgeon and clinical staff to review and rely upon this information in providing care, including the use of local anesthesia, sedation, or general anesthesia, when indicated. I have had the opportunity to ask questions regarding my health history and proposed care.

_____ _____ _____

DATE SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DOCTOR'S INITIALS

MEDICAL UPDATE

I have reviewed my Health History dated _____ and confirm that it accurately reflects my past and present medical conditions. Any changes or exceptions are noted below.

_____

EXCEPTIONS OR CHANGES

_____ _____ _____

DATE PATIENT'S SIGNATURE DOCTOR'S INITIALS

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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____
Social Security #: _____ Employer: _____
Phone: _____ Email: _____
Address: _____
City: _____ State: _____ ZIP: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐ (Check here if same as above)
Name: _____ Relationship: _____
Phone: _____ Employer: _____
Email: _____
Address: _____
City: _____ State: _____ ZIP: _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: _____
Subscriber Name: _____ Subscriber DOB: _____
Policy/Member ID or Social Security #: _____
Group #: _____ Relationship to Patient: _____
Employer: _____

MEDICAL INSURANCE INFORMATION

Primary Medical Insurance: _____
Subscriber Name: _____ Subscriber DOB: _____
Policy/Member ID or Social Security #: _____
Group #: _____ Relationship to Patient: _____
Employer: _____

DENTIST AND PHYSICIAN INFORMATION

Dentist Name: _____ Referred By: _____
Dentist Phone #: _____ Dentist Fax #: _____
Physician Name: _____ Physician Phone #: _____
Pharmacy Name: _____ Pharmacy Phone #: _____
Pharmacy Address: _____

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AUTHORIZATION TO SHARE HEALTH INFORMATION

Patient's Name: _____

I authorize Dr. Arango and the office staff at Andrew Arango Oral & Facial Surgery to discuss my care with the people listed below:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of patient or patient's representative Date

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PATIENT FINANCIAL POLICY

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK PRIOR TO INITIALING

____ 1. I, the undersigned, hereby authorize payment of any insurance benefits to be made directly to Andrew Arango Oral & Facial Surgery.

____ 2. I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payments to Andrew Arango Oral & Facial Surgery are not contingent of any settlement, judgement, or verdict by which the patient may eventually recover said insurance benefit payment(s).

____ 3. I hereby agree that I, the undersigned, shall be liable for any reasonable attorney's fees and/or collection costs incurred by Andrew Arango Oral & Facial Surgery if such bills are placed with an attorney or third party.

____ 4. I hereby authorize Andrew Arango Oral & Facial Surgery to release all financial, health, and other information to my insurance company or my representative, including any attorney of record.

____ 5. I hereby authorize any physician, health care practitioner, dentist, hospital, or medical care facility to provide all information on the patient's history to Andrew Arango Oral & Facial Surgery.

____ 6. I agree that all procedures performed in-office at Andrew Arango Oral & Facial Surgery will be subject to any applicable dental insurance benefits. I agree that all procedures performed in office will not be subject to medical insurance benefits. As a courtesy, our office will provide the patient with all documentation needed for the patient to file their own medical insurance claim.

____ 7. I hereby authorize photocopies of this form to be valid. I am fully aware of the contents of this form. I agree with this financial policy of Andrew Arango Oral & Facial Surgery.

I certify that I speak, read, and write English and have read and fully understand this consent and have had my questions answered.

_____ _____

Signature of patient or Legal Representative Date

_____

Print Patient or Legal Representative Name/Relationship

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CREDIT CARD / PAYMENT AUTHORIZATION

It is not possible for our office to know the exact details of every insurance plan. Non-covered services, deductible amount, remaining annual maximum benefit, claims in process from other offices, and co-insurance responsibility are all variable. The exact patient responsibility amount is unknown at the time of your appointment(s).

We are happy to provide an estimate for your procedure(s) based on the information we receive from your insurance company. We are also happy to file insurance claims for you as a courtesy.

All insurance companies have the same rule when we call to verify your coverage details: **any information provided by the insurance company via phone conversation or a faxed document does not guarantee coverage or payment from the insurance company.**

Exact patient responsibility is unknown until the insurance company processes the claim.

If you would like our office to file and maintain your insurance claims, we ask for an updated credit card to keep on file in order to charge any remaining patient out-of-pocket responsibility, up to $500, after the insurance company has paid their portion. Should your remaining responsibility exceed $500, we will notify you prior to charging your credit card. In order to cancel this authorization, please send written authorization to Andrew Arango Oral & Facial Surgery at the address listed above.

If you prefer to pay your balance in full and be reimbursed by your insurance company directly, we will not need this information.

Name of Patient: _____

Name on card: _____

Card number: _____

Expiration Date: _____ CVV: _____ Zip code: _____

Signature of card holder: _____

Date: _____

Relationship to patient: self parent legal guardian spouse child
(please choose one)