WELCOME TO OUR PRACTICE

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JAMES J. BABIUK, DDS
THE CENTRE FOR ORAL SURGERY IN JOLIET
C.O.S JOLIET

PATIENT INFORMATION

Mr. Mrs. Ms. Miss Name _____ Nickname _____
Birth Date _____ S.S. # _____ Driver's License# _____
Address _____ Apartment # _____
City _____ State _____ Zip _____
Phone # _____ Cell # _____ E-mail _____
Emergency Contact (Name) _____
Relationship to Patient _____ Phone # _____

REFERRAL INFORMATION

Referred by _____
Patient's Dentist _____ Physician _____
Has any member of your family been a patient here? ☐ Yes ☐ No Name _____

ACCOUNT INFORMATION

Person Responsible for Account (if other than patient):
Name _____ S.S.# _____
Relationship _____ Birth Date _____
Address/P.O.Box _____ Apartment # _____
City _____ State _____ Zip _____
Driver's License # _____ Phone # _____
Employer _____ Work # _____

INSURANCE INFORMATION

To all patients, please provide the most recent dental and/or medical insurance card.

Primary Dental Insurance

Ins. Co. Name _____
Address _____
Phone # _____
Group # _____
I.D. # _____
Insured Party _____
Relation _____
Employer _____
Bus. Phone # _____
Birth Date _____
S.S. # _____

Primary Medical Insurance

Ins. Co. Name _____
Address _____
Phone # _____
Group # _____
I.D. # _____
Insured Party _____
Relation _____
Employer _____
Bus. Phone # _____
Birth Date _____
S.S. # _____

Secondary Dental Insurance

Ins. Co. Name _____
Address _____
Phone # _____
Group # _____
I.D. # _____
Insured Party _____
Relation _____
Employer _____
Bus. Phone # _____
Birth Date _____
S.S. # _____

Secondary Medical Insurance

Ins. Co. Name _____
Address _____
Phone # _____
Group # _____
I.D. # _____
Insured Party _____
Relation _____
Employer _____
Bus. Phone # _____
Birth Date _____
S.S. # _____

HEALTH QUESTIONNAIRE

To our patients: Please complete the information below as accurate as possible as any medical condition and/or medications you may be taking may have serious interactions with the medications and/or procedures administered/performed by Dr. Babiuk. The information provided here is strictly confidential.

- Have there been any changes in your general health in the past year? ☐ Yes ☐ No
- Have you been under the care of a physician in the past year? ☐ Yes ☐ No
  If yes: date of your last visit? _____
  If so, for what condition are you being treated? _____
- Have you had any illness, operation or been hospitalized in the past five years? ☐ Yes ☐ No
  If so, describe _____
- Do you have a prosthetic joint/implant? ☐ Yes ☐ No
  If so, describe where? _____
- Have you had a heart valve replacement or vascular graft? ☐ Yes ☐ No
  If so, describe what type and when? _____

HAVE YOU OR DO YOU CURRENTLY HAVE

1. Rheumatic fever? ☐ Yes ☐ No
2. Damaged heart valves/mitral valve prolapse? ☐ Yes ☐ No
3. Heart murmur? ☐ Yes ☐ No
4. High blood pressure? ☐ Yes ☐ No
5. Low blood pressure? ☐ Yes ☐ No
6. Chest pain/angina? ☐ Yes ☐ No
7. Heart attack(s)? ☐ Yes ☐ No
8. Irregular heart beat? ☐ Yes ☐ No
9. Cardiac pacemaker? ☐ Yes ☐ No
10. Heart surgery? ☐ Yes ☐ No
11. Bronchitis, chronic cough? ☐ Yes ☐ No
12. Asthma? ☐ Yes ☐ No
13. Hay fever/sinus problems? ☐ Yes ☐ No
14. Snoring/sleep apnea? ☐ Yes ☐ No
15. Difficult breathing/other lung trouble? ☐ Yes ☐ No
16. Tuberculosis? ☐ Yes ☐ No
17. Emphysema? ☐ Yes ☐ No
18. Bruise easily? ☐ Yes ☐ No
19. Bleeding tendency? ☐ Yes ☐ No
20. Hepatitis, jaundice or liver disease? ☐ Yes ☐ No
21. Fainting spells? ☐ Yes ☐ No
22. Convulsions/epilepsy? ☐ Yes ☐ No
23. Stroke? ☐ Yes ☐ No
24. Thyroid trouble? ☐ Yes ☐ No
25. Diabetes? ☐ Yes ☐ No
26. Low blood sugar? ☐ Yes ☐ No
27. Kidney trouble? ☐ Yes ☐ No
28. Are you on dialysis? ☐ Yes ☐ No
29. Swollen ankles, arthritis or joint disease? ☐ Yes ☐ No
30. Stomach ulcers? ☐ Yes ☐ No
31. HIV/AIDS? ☐ Yes ☐ No
32. Problems with the immune system? ☐ Yes ☐ No
33. A tumor or growth? ☐ Yes ☐ No
34. Radiation therapy/Chemotherapy? ☐ Yes ☐ No
35. Chronic fatigue/night sweats? ☐ Yes ☐ No
36. Eye disease/Glaucoma? ☐ Yes ☐ No
37. Mental health problems? ☐ Yes ☐ No
38. Depression/Anxiety? ☐ Yes ☐ No
39. Malignant hyperthermia? ☐ Yes ☐ No
40. Blood Transfusion? ☐ Yes ☐ No
41. Mononucleosis? ☐ Yes ☐ No
42. Delayed Healing? ☐ Yes ☐ No
43. Gall Bladder Trouble? ☐ Yes ☐ No
44. Pain or Clicking of jaws when opening or closing? ☐ Yes ☐ No
45. Other Medical issues not listed? _____

Notes _____

_____

_____

SOCIAL HABITS

Do you chew or smoke tobacco? ..... ☐ Yes ☐ No (If yes, how much? And for how long) _____

Do you drink alcoholic beverages?..... ☐ Yes ☐ No (If yes, how much? And for how long) _____

Do you use any illicit drugs?..... ☐ Yes ☐ No (If yes, how much? And for how long) _____

MEDICATION – Are you taking or have you taken...

Any kind of medication, drug, pills? ..... ☐ Yes ☐ No

Blood thinners (Coumadin, Plavix, Aspirin, Ginko Biloba)?..... ☐ Yes ☐ No

Any osteoporosis or bone density medications (Aredia, Zometa, Fosamax, Actonel)? ..... ☐ Yes ☐ No

Any herbal supplement, homeopathic formulation or diet pills (Fen-phen)?..... ☐ Yes ☐ No

Please list any medications you are currently taking: _____

_____

_____

ALLERGIES – Are you allergic to, or had a reaction to...

Local anesthetics (numbing medications)?..... ☐ Yes ☐ No

Antibiotics (Penicillin, Sulfa, other)? ..... ☐ Yes ☐ No

Aspirin? ..... ☐ Yes ☐ No

Codeine or other narcotics? ..... ☐ Yes ☐ No

Latex?..... ☐ Yes ☐ No

Please list any allergies other than drug allergies_____

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

If so, describe _____

FAMILY HISTORY

Cancer ..... ☐ Yes ☐ No

Diabetes ..... ☐ Yes ☐ No

Heart Disease..... ☐ Yes ☐ No

Problems with General Anesthesia ..... ☐ Yes ☐ No

SECTION FOR FEMALE PATIENTS ONLY

Are you pregnant? ..... ☐ Yes ☐ No

If yes, expected delivery date _____

Are you nursing?..... ☐ Yes ☐ No

I have been given the opportunity to inquire about any question(s) that are not understood. By signing here, I certify that I read and understand the questions above and I will not hold Dr. Babiuk or his associates responsible for any omissions or errors made during the completion of this form. I acknowledge that any Oral Surgeon treating me in this office other then Dr. Babiuk are independent contractors and are individually responsible for their treatment.

Signature of Patient/Custodial Guardian _____Date _____

AUTHORIZATION

I authorize Dr. Babiuk and his associates, to perform an oral examination and to take all x-rays deemed necessary for the purpose of diagnosis and treatment planning.

FINANCIAL INFORMATION

Several factors determine the fee for Oral Surgery services, including the complexity and advancement of the situation; you will be informed of any fees before treatment is started. We understand your health care or dental insurance may not cover all of the cost of your treatment, and we make every effort to help you maximize your coverage and increase your reimbursement. Financial options will also be discussed during the initial visit.

It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collections, attorneys and court fees if the account is in default.

Signature of Patient/Custodial Guardian _____Date _____

Reviewed by _____Date _____