Allergy

For official use



DR. DONOVAN R. HANSEN DDS

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Date:		
Patient Name:	Ge	nder: () M () F Birth date:
Last Fir	st MI (Preferred Name)	
Family Status: () Married () Sing	le () Child () Other	Social Security#:
Address:	City:	State: Zip:
		nail:
Who is financially responsible for this	s natient? (Name)	(phone)
· -		
Who can we notify in case of emerger	ncy? (Name)	(phone)
		card, photo ID, and information below.
Insured (subscriber) Name:	Date of birth	ID #
Name of Insurance	Group #	Employer
I have Medicare as part of my medical i	nsurance coverage: () YES () NO	
Whom may we thank for refer	ring you to our practice?	
· · · · · · · · · · · · · · · · · · ·	2	Print () Yellow Pages () School () Work
() Another patient, iriend /relative (nar	ne:) () Other
Reason for your visit today:		
·	ollowing? Please check those that	
Y N	Y N	Y N
() () AIDS	() () Fainting	() () Nervous Disorders
() () Allergies	() Glaucoma	() Osteoporosis
() () Anemia	() () Grind or Clench Teeth	() () Pacemaker
() () Arthritis	() () Hay Fever	() () Radiation Treatment
() () Angina/Chest Pain	() () Heart Valve Replacement	
() () Artificial Joints/implant	() () Heart Attack	() () Rheumatic Fever
() () Asthma	() () Heart Surgery	() () Rheumatism
() () Autism	() () Heart Disease	() () Seizures/Convulsions
() Blood Disease	() () Heart Murmur	() () Sinus Problems
() () Blood Transfusion () () Cancer	() () Heart Palpitations() () Head Injuries	() () Stomach Problems () () Stroke
() Cancer () Chronic Cough	() () High Blood Pressure	() () Thyroid Disease
() Clicking/Popping Jaw	() () Hepatitis	() () Tuberculosis
() () Dizziness	() () HIV	() () Tumors
() () Depressed Immune Sys	() () Kidney Disease	() () Ulcers
() Diabetes	() () Liver Disease	() () Pregnant
() () Epilepsy	() () Lung Disease	() () Any chance of Pregnancy
() () Emphysema	() () Mental Disorders	Due Date:
() () Excessive Bleeding	() () Jaundice	() () Are you nursing?
() () Other:		

Are you using any of the following? Please circle all that apply:

Please list any other medications you are taking including prescription medications, diet drugs, over-the-counter medications, herbal for holistic remedies, vitamins or minerals:

Have you ever used any of the following? Please check those that apply: Bisphosphonates: Fosamax, Actonel, Boniva, Aredia, or Zometa (For Osteoporosis/Cancer). Phen-Fen Are you allergic to or have you had an adverse reaction to any of the following? Please circle all that apply: Local Anesthesia Penicillin Antibiotics Sedatives **Barbiturates** Aspirin **Ibuprofen** Codeine **Pain Killers** Latex Rubber Sulfa **Eggs** Milk OTHER: *Do you have any health problems that need further clarifications? () Yes () No If yes, please explain: *Have you ever had any complications following dental treatment? () Yes () No If yes, please explain: *Do you smoke or chew Tobacco products? () Yes () No If yes, how much per day: _____ *Have you ever had past history of alcohol, chemical dependency or emotional disorders? () Yes () No If yes, please explain: *Have you or an immediate family member ever had any problems associated with intravenous anesthesia? () Yes () No If yes, please explain: *Have you been admitted to a hospital or needed emergency care during the past two years? () Yes () No If yes, please explain: *Name of Physician: Phone: *If you are using oral contraceptives, it is important to 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. *Do you wish to talk to the doctor privately about anything? () Yes () No To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. Desert Valley Oral Surgery and Dr. Donovan Hansen DDS is not a participating provider under any state funded AHCCCS or Medicare programs. As an OPT-OUT provider with no authorization to perform services, the charges for services rendered cannot be billed to your health plan. As a practice, Desert Valley Oral Surgery does not accept reduced fees from these programs nor do we provide billing information. I agree any services rendered in this facility are solely my financial responsibility and I agree to make payments in full at the time of services, unless prior arrangements have been made. I am fully aware that I have the choice to have services performed under these terms or I can choose to seek treatment with a participating provider. In the event that any of the office staff of Desert Valley Oral Surgery is injured while performing patient treatment (i.e. needle stick, puncture wound, etc.), Desert Valley Oral Surgery has my full consent to draw blood for the purpose of laboratory testing. This will ensure the safety of all parties who are concerned and involved. ______, represents that I am legally authorized to obtain medical services for the patient who is a minor or is under my custodial care. Signature of patient, parent or guardian Date

Signature of Doctor