Welcome to our Practice

Today's Date 05/01/2019

PATIENT INFORMATION:

☑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name Deven M.I. S Last Name Dallmann

Sex: ☑ Male ❑ Female Birth Date 06/06/1965 Age 53 Soc. Sec. # 529-04-2315 E-mail deven.dallmann@gmail.com

Street 397 Rose Ave Apt. _____ City Pleasanton State Ca Zip 94566

Home Tel.(925) 580-1494 Cell.(925) 580-1494 Have you ever been a patient of our practice? ❑ Yes ☑ No

Referred By Mona (FIRST NAME) Gokani (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ☑ No

Dentist Pleasanton Ridge (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. Jeffrey (FIRST NAME) Wherry (LAST NAME) Preferred Pharmacy Safeway Bernal Tel.(_____) _____

Driver's Lic.# C5176132 Nearest relative not living with you Donna (FIRST NAME) Dallmann (LAST NAME) Tel.(307) 887-7571

Employer Squeegee Brothers Inc. Bus. Tel.(925) 580-1494 Personal Payment Type: ❑ Cash ❑ Check ☑ Credit Card

In case of emergency, please contact Lisa Dallmann Tel. (925) 580-1495 Relation Wife

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

☑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name Deven (FIRST NAME) Dallmann (LAST NAME) S.S.# 529-04-2315 Birth Date 06/06/1965 Age 53

Tel.(925) 580-1494 Cell. (925) 580-1494 E-mail deven.dallmann@gmail.com

Street 397 Rose Ave Apt. _____ City Pleasanton State Ca Zip 94566

Driver's Lic.# C5176132 Employer Squeegee Brothers Inc. Bus. Tel.(925) 580-1494

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ☑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ☑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ☑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ☑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer Squeegee Brothers Inc.

Bus. Address 397 Rose Ave (ADDRESS) Pleasanton (CITY) ca (STATE) 94566 (ZIP)

Bus. Tel.(925) 580-1494 Plan Dental PPo

Ins. Co. Name Blue Shield of Californ I.D. # 908891787

Address PO Box 30567 (ADDRESS) Salt Lake City (CITY) UT (STATE) 84130 (ZIP)

Tel.(888) 271-4880 Group Name _____

Group # _____ Insured Party Deven (FIRST NAME) Dallmann (LAST NAME)

Relation Self Birth Date 06/06/1965 Sex: ☑ M ❑ F

S.S. # 529-04-2315 Tel.(925) 580-1494

Address 397 Rose Ave (ADDRESS) Pleasanton (CITY) Ca (STATE) 94566 (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer Squeegee Brothers Inc.

Bus. Address 397 Rose Ave (ADDRESS) Pleasanton (CITY) ca (STATE) 94566 (ZIP)

Bus. Tel.(925) 580-1494 Plan Bronze 60 HDHP PPO

Ins. Co. Name Blue Shield I.D. # XEK908891787

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party Deven (FIRST NAME) Dallmann (LAST NAME)

Relation Self Birth Date 06/06/1965 Sex: ☑ M ❑ F

S.S. # 529-04-2315 Tel.(925) 580-1494

Address 397 Rose Ave (ADDRESS) Pleasanton (CITY) Ca (STATE) 94566 (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

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 that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit? Infected tooth, pain

		Yes	No
1.	***Height*** 5'10" ***Weight*** 205 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? ***Date of last visit*** _____	☐	☑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	☐	☑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	☐	☑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	☐	☑
7.	Have you had a heart valve replacement or vascular graft?	☐	☑
8.	Have you ever had general anesthesia?	☑	☐
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	☐	☑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☑	☐

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?		✔	
12. Damaged heart valves / mitral valve prolapse?		✔	
13. Heart murmur?		✔	
14. High blood pressure?		✔	
15. Low blood pressure?		✔	
16. Chest pain / angina?		✔	
17. Heart attack(s)?		✔	
18. Irregular heart beat?		✔	
19. Cardiac pacemaker?		✔	
20. Heart surgery?		✔	
21. Pneumonia, bronchitis, chronic cough?		✔	
22. Asthma?		✔	
23. Hay fever / sinus problems?	✔		
24. Snoring?	✔		
25. Sleep apnea / CPAP?		✔	
26. Difficult breathing / other lung trouble?		✔	
27. Tuberculosis?		✔	
28. Emphysema?		✔	
29. Do you smoke or vape? If so, how much a day_____		✔	
30. Do you use chewing tobacco?		✔	
31. Blood transfusion?		✔	
32. Blood disorder such as anemia?		✔	
33. Bruise easily?		✔	
34. Bleeding tendency / abnormal bleed?		✔	
35. Hepatitis, jaundice, or liver disease?		✔	
36. Infectious mononucleosis?		✔	
37. Gallbladder trouble?		✔	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells?		✔	
39. Convulsions / epilepsy?		✔	
40. Stroke?		✔	
41. Thyroid trouble?		✔	
42. Diabetes?		✔	
43. Low blood sugar?		✔	
44. Kidney trouble?		✔	
45. High cholesterol?		✔	
46. Are you on dialysis?		✔	
47. Swollen ankles / arthritis / joint disease?		✔	
48. Osteoporosis / osteopenia?		✔	
49. Osteonecrosis?		✔	
50. Stomach / acid reflux?	✔		
51. Contagious diseases?		✔	
52. Sexually transmitted diseases?		✔	
53. Problems with immune system? Possibly from medication / surgery, etc.		✔	
54. Delay in healing?		✔	
55. A tumor or growth?		✔	
56. Cancer / radiation therapy / chemotherapy?		✔	
57. Chronic fatigue / night sweats?		✔	
58. Are you on a diet?		✔	
59. A history of alcohol abuse?		✔	
60. A history of marijuana or other drug use?		✔	
61. Contact lenses?		✔	
62. Eye disease / glaucoma?		✔	
63. Mental health problems / anxiety / depression?		✔	
64. A removable dental appliance?		✔	
65. Pain or clicking of jaws when eating?		✔	

WOMEN ONLY: *(QUESTIONS 66–69)*

	Yes	No
66. Is there a possibility of pregnancy?	❑	❑
67. Expected delivery date?_____		
68. Are you nursing?	❑	❑
69. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
70. Any kind of medication, drug, pills?	✔		
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)?		✔	
72. Have you ever taken diet pills?		✔	
73. Any natural product, herbal supplement or homeopathic remedy?	✔		
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?		✔	

75. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

76. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other_____

Treating doctor:_____ _____
FIRST NAME LAST NAME

77. Please list any medications you are currently taking:

Medication	Dosage	Frequency
amoxicillin		2x/day

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? Lisa Dallmann

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ☑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ☑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
78. Local anesthetic (numbing meds.)?		✔	
79. Penicillin?		✔	
80. Other antibiotics?		✔	
81. Sulfa drugs?		✔	
82. Sodium pentothal / Valium /other tranquilizers?		✔	
83. Aspirin?		✔	
84. Amoxicillin?		✔	
85. Codeine or other narcotics?		✔	
86. Latex?		✔	
87. Soy?		✔	
88. Eggs / yolk?		✔	
89. Sulfites?		✔	
90. Do you have any known allergies?		✔	

91. Please list any allergies other than drug allergies:

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

Medication / Antibiotic Name

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ☑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury_____

Insurance company handling the claim_____

Claim number_____

Name of attorney / adjustor_____

Telephone number (_____)_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X Deven Dallmann	X 5/1/2019	X	X
Signature of patient *(Parent or Guardian if Minor)*	**Date**	**Reviewed by**	**Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor 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 company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X Deven Dallmann	X 5/1/2019
Signature of patient *(Parent or Guardian if Minor)*	**Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X Deven Dallmann	X 5/1/2019
Signature of patient: *(Parent or Guardian if Minor)*	**Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X Deven Dallmann	X	X 5/1/2019
Signature of patient *(Parent or Guardian if Minor)*	**Doctor**	**Date**

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.

X Deven Dallmann	X 5/1/2019
Signature of patient *(Parent or Guardian if Minor)*	**Date**