

STEPHEN L WHEELER, D.D.S. INC
JOHN SEUL, D.M.D., M.D.

ORAL AND MAXILLOFACIAL SURGERY
DENTAL IMPLANT RECONSTRUCTION

320 Santa Fe Drive Suite 304, Encinitas CA 92024
(760) 942-1333

Date: _____

Name: _____ SSN: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone#: _____ 2nd Phone: _____ 3rd Phone: _____

Parent[s] Name if Minor: _____ Patient Spouse's Name: _____

Student Status Full or Part Time, School Name: _____ City: _____ State: _____

Dentist: _____ Referred by: _____ Physician: _____ MD Phone #: _____

Why do you seek treatment today? _____

* * *PLEASE ANSWER THE FOLLOWING QUESTIONS BY INDICATING YES OR NO* * *

YES NO

Are you currently under care by a doctor for a medical condition? If so, what condition? _____

Are you currently taking any medications or herbal supplements? Please list: _____

Have you ever taken a bisphosphomate medication (ie. Fosomax, Actonel, Zomeda, Aredia?) _____

Are you allergic to any medications? Please list: _____

Do you pre-medicate with antibiotics before a dental procedure due to a medical condition?

Have you ever had any excessive bleeding requiring medical attention? _____

Do you smoke? If yes, how much? _____

Have you ever had any of the following? If so, please indicate:

_____ Pacemaker	_____ Egg Allergy	_____ Hepatitis (A, B or C)
_____ Heart Disease	_____ Liver Disease	_____ Drug or Alcohol Addiction
_____ Heart Murmur	_____ Epilepsy or Seizures	_____ Ulcers
_____ Mitral Valve Prolapse	_____ High Blood Pressure	_____ Anemia
_____ Rheumatic Fever	_____ Artificial Prosthesis	_____ Diabetes
_____ Stroke	_____ Kidney Disease	_____ Thyroid Disease
_____ Respiratory Disease	_____ Tuberculosis	_____ T.M.J. Problems
_____ Glaucoma	_____ HIV +	

Do you have any disease or medical problems not listed? If so, what are they? _____

(Female) Are you pregnant? If so, how far along? _____ months. Do you plan to be soon? _____

When was your last menstrual period? _____

Have you had an unfavorable reaction to medical or dental treatment or anesthetics of any kind? _____

Are you wearing contact lenses? If so, hard or soft? _____

What is your height? _____ Weight? _____ lbs.

Patient's Employer: _____ Position: _____

Employer's Address: _____ Work Phone: _____

Name of Dental Insurance: _____ Medical Insurance: _____

Insurance Subscriber Name: _____ SS#: _____ Date of Birth: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Subscriber/Parent Employer: _____ Position: _____

Employer's Address: _____ Work Phone: _____

It is customary to pay for services at the time of treatment. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. (I further understand that a 1.5% finance charge 18% annually will be added to any balance over 90 days.) I authorize payment directly to the practice from the insurance company.

Signature: _____ Date: _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM TO MY INSURANCE COMPANY.