COASTAL
ORAL SURGERY & DENTAL IMPLANT CENTER

Anthony Pitrowski, DMD, MD
Kenneth M. Goldberg, DMD

General Patient Information

Thank you for selecting our oral surgical team! We strive to provide you with the best possible care. To help us meet all your surgical healthcare needs, please fill out this form completely. If you need any assistance or have any questions, please ask our friendly staff - we will be happy to help.

PATIENT INFORMATION:

Referred By: ____________________

Patient Full Name: ____________________ ☐ Male ☐ Female

Age: ________ Birth Date: ____________ Soc. Sec. #: ______________ Ph#: ______________

Secondary Ph#: ______________ Email Address: ____________________

Address: ____________________ City: ____________ State: ________ Zip: ________

Employer: ______________ Occupation: ______________ Work Ph#: ______________

EMERGENCY CONTACT:

Name: ____________________ Relationship to Patient: ______________

Ph#: ______________ Secondary Ph#: ______________

RESPONSIBLE PARTY:

Full Name: ____________________ Relationship to Patient: ______________

Age: ________ Birth Date: ____________ Soc. Sec. #: ______________ Ph#: ______________

Secondary Ph#: ______________ Email Address: ____________________

Address: ____________________ City: ____________ State: ________ Zip: ________

Employer: ______________ Occupation: ______________ Work Ph#: ______________

DENTAL INSURANCE INFORMATION:

Primary Insurance

Name of Insured: ____________________ Relationship to Patient: ______________

Insured's Address: ____________________ City: ____________ State: ________ Zip: ________
(If Different From Patient)

Insured's Birth Date: ____________ Soc. Sec. #: ______________ Employer: ______________

Insurance Company: ____________________ Group#: ______________ ID# ______________

Insurance Address: ____________________ City: ____________ State: ________ Zip: ________

Secondary Insurance

Name of Insured: ____________________ Relationship to Patient: ______________

Insured's Address: ____________________ City: ____________ State: ________ Zip: ________
(If Different From Patient)

Insured's Birth Date: ____________ Soc. Sec. #: ______________ Employer: ______________

Insurance Company: ____________________ Group#: ______________ ID# ______________

Insurance Address: ____________________ City: ____________ State: ________ Zip: ________

I authorize Coastal Oral Surgery & Dental Implant Center to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child, to third-party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable by me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

Signature: ________________________________ Date: ______________

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Medical History

Name: ______________________ Date: __________
Height: __________ Weight: __________ Age: __________

ALLERGIES: Are you sensitive or allergic to any of the following?

☐ Local Anesthetic ☐ Sulfa Drugs ☐ Aspirin ☐ Tylenol ☐ Food (e.g., Soy, Egg)
☐ Penicillin ☐ Codeine ☐ Ibuprofen ☐ Latex

Please list all other known allergies : ____

____

MEDICATIONS:
Please list all current medications, including non-prescription, natural remedies, and vitamins:

____

____

- Have you been a patient in a hospital during the past year? .... ☐ Yes ☐ No
- In the past two (2) years, have you had a serious illness requiring a physician's care? ..... ☐ Yes ☐ No
- Physician's Name: ______________________ Dentist's Name: ______________________
- List prior operations: ____

____

- Have you had or do you currently have:

☐ Stroke
☐ Heart Disease or Attack
☐ Angina
☐ Heart Murmur
☐ High/Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Heart Pacemaker
☐ Heart Surgery
☐ Rheumatic Fever
☐ Artificial Heart Valve
☐ Artificial Joints (Hip, Knee, Etc.)
☐ TMJ (Jaw Joint) Problems
☐ Lyme Disease
☐ Headaches/Migraines
☐ Psychiatric Problems
☐ Ulcers
☐ Diabetes
☐ Thyroid Problems
☐ Glaucoma
☐ Cancer
☐ Chemotherapy
☐ Osteoporosis Therapy (Fosamax/Boniva, Etc.)
☐ Emphysema
☐ Tuberculosis
☐ Asthma
☐ Allergies
☐ Sinus Problems
☐ Blood Disorders
☐ Hepatitis A, B, C, or D
☐ Liver Disease
☐ HIV Positive
☐ Blood Transfusion
☐ Hemophilia
☐ Anemia
☐ Bruise Easily
☐ Epilepsy/Seizures
☐ Fainting/Dizzy Spells
☐ Drug Addiction
☐ Use of Diet Pills
☐ Use of Health Food Supplements

- Please list any other disease, condition, or problem not listed above: ______________________

____

- Do you smoke? ☐ Yes ☐ No If yes, how often?: ______________________
- Do you drink? ☐ Yes ☐ No If yes, how often?: ______________________

WOMEN ONLY:

- Are you pregnant? .... ☐ Yes ☐ No
  If yes, how many months?: __________
- Are you nursing? .... ☐ Yes ☐ No
- Are you on birth control pills? .... ☐ Yes ☐ No

I understand the above information is necessary to provide safe surgical treatment. I have answered all questions truthfully and to the best of my knowledge.

Signature: ______________________________ Date: __________
(Parent or Legal Guardian, if Minor)
X ______________________________ Date: __________
X ______________________________ Date: __________
X ______________________________ Date: __________

Dr. Signature: ______________________________ Date: __________