Patient Information

Todays Date _____

Dr. Bruce J. Cutilli
Oral & Maxillofacial Surgery, LLC
809 N. Bethlehem Pike P.O. Box 857
Spring House, PA 19477
215-591-9354

Name _____Age _____Birthdate _____
Address (Street) _____
City _____Zip Code_____Home Phone_____
Patient Social Security Number _____Cell Phone_____
Email Address _____ Work Phone_____
Employer Name _____Occupation_____

Person Responsible for account if other than the patient:

Name _____Relationship_____Birthdate _____
Address (Street) _____
City_____Zip Code_____Home Phone_____
SS #of responsible party _____
Employer Name _____Occupation_____

Dental Insurance:

Name of Primary Dental Insurance _____
Subscribers Name _____Date of Birth_____
Insurance Company Address_____
ID or Agreement # _____Policy or Group #_____
Name of Secondary Dental Insurance _____
Subscribers Name _____Date of Birth_____
ID or Agreement # _____Policy or Group #_____

Medical Insurance:

Subscribers Name _____ Date of Birth_____
Name of Primary Medical Insurance _____
Insurance Company Address_____
ID or Agreement # _____Policy or Group #_____

Pharmacy Name/Address:_____Phone_____
_____

In case of emergency notify: Name_____Phone_____
Dentist _____Phone_____
Address _____
Family Physician _____Phone_____
Address _____

Assignment of Benefits and Release of Information

I authorize payment of medical benefits to **Dr. Bruce J. Cutilli, Oral and Maxillofacial Surgery, LLC** for professional services rendered. I understand I am financially responsible for all charges not covered by my insurance. I authorize the release of any or all information necessary to process my insurance claim.

Signed _____Date_____
Subscriber's Name

Medical Health History

List all medical conditions:

_____

_____

_____

Please <u>circle</u> any of the following which you have had:

Heart Disease	Chest Pains	Numbness	Sleep Apnea
Heart Murmur	Shortness of Breath	Arthritis	
Rheumatic fever	Stroke	Fainting	
High Blood Pressure	Diabetes	AIDS / HIV	
Asthma	Cancer	Artificial Joints	
Spontaneous Bruising	Sinus Trouble	Artificial Heart Valves	
Severe Bleeding	Blood Disorders	Shunts	
Bleeding Disorder	Kidney Disease	Epilepsy	
Hepatitis	Psychiatric Treatment	TMJ Disorder	
Liver Problems	Seizure Disorders	Anesthesia Allergies	
Leg or Ankle Swelling	Stomach Ulcers	Do you smoke- Yes No	

Have you been a patient in the Hospital or Emergency room in the past?	Y	N
Have you been under the care of a physician during the past two years?	Y	N
Are you taking aspirin or any other blood thinners?	Y	N
Are you taking steroid medications?	Y	N
Do you have any artificial joints, bone plates, or screws?	Y	N
Do you have any artificial heart valves or damaged heart valves?	Y	N
Have you ever had excessive bleeding after surgery or after dental extractions?	Y	N
Have you or any member of your immediate family have a history of excessive bleeding?	Y	N
Have you had chemo-therapy?	Y	N
Have you ever had radiation therapy?	Y	N
Have you had a positive test for Hepatitis or the AIDS virus?	Y	N
(Women) Are you pregnant now?	Y	N
(Women) Are you taking birth control pills?	Y	N
Have you ever taken **Fosamax**, **Actonel**, **Boniva**, **Zometa**, **Aredia** or **Bisphosphonate** drugs?	Y	N
Are you allergic to penicillin or any other antibiotic? (Please list below)	Y	N
Do you have any allergies to medications (Please list below)	Y	N
Do you have any allergies to anesthesia or reactions to anesthesia in the past?	Y	N

What medications are you currently taking or have taken in the past two years? Include over-the-counter medicines. List any nutritional supplements you are presently taking. (Please list below)

List All Current Medications:	**List Medication Allergies:**
Patient Signature:	Date:

Medical History Update:

Date: _____ Comments: _____ Dr. Initials:_____

Date: _____ Comments: _____ Dr. Initials:_____

Date: _____ Comments: _____ Dr. Initials:_____