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_____
Employer Name _____Occupation_____
Employer Address _____Work Phone_____
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_____
Employer Address _____Work Phone_____
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 #_____
In case of emergency notify:
Name_____Phone_____
Address _____

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

Please check any of the following which you have had:

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Rheumatic fever
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Spontaneous Bruising
- ☐ Severe Bleeding
- ☐ Bleeding Disorder
- ☐ Hepatitis
- ☐ Liver Problems
- ☐ Leg or Ankle Swelling
- ☐ Chest Pains
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Sinus Trouble
- ☐ Blood Disorders
- ☐ Kidney Disease
- ☐ Psychiatric Treatment
- ☐ Seizure Disorders
- ☐ Stomach Ulcers
- ☐ Numbness
- ☐ Arthritis
- ☐ Fainting
- ☐ AIDS / HIV
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Shunts
- ☐ Epilepsy
- ☐ TMJ Disorder
- ☐ Anesthesia Allergies

List Other Medical Conditions:

	YES	NO
Do you smoke?	☐	☐
Have you been a patient in the Hospital or Emergency room in the past?	☐	☐
Have you been under the care of a physician during the past two years?	☐	☐
Are you taking aspirin or any other blood thinners?	☐	☐
Are you taking steroid medications?	☐	☐
Do you have any artificial joints, bone plates, or screws?	☐	☐
Do you have any artificial heart valves or damaged heart valves?	☐	☐
Have you ever had excessive bleeding after surgery or after dental extractions?	☐	☐
Have you or any member of your immediate family have a history of excessive bleeding?	☐	☐
Have you had chemo-therapy?	☐	☐
Have you ever had radiation therapy?	☐	☐
Have you had a positive test for Hepatitis or the AIDS virus?	☐	☐
(Women) Are you pregnant now?	☐	☐
(Women) Are you taking birth control pills?	☐	☐
Have you ever taken **Fosamax**, **Actonel**, **Boniva**, **Zometa**, **Aredia** or **Bisphosphonate** drugs	☐	☐
Are you allergic to any medications including penicillin or other antibiotic? (Please list below)	☐	☐
Do you have any allergies to anesthesia or reactions to anesthesia in the past?	☐	☐

What medications are you currently taking? (Include over-the-counter medicine and nutritional supplements.)

	Please List Allergies to Medications: