Todd K. Haruki, DDS, MD
Neil Oishi, DDS, MD

PATIENT INFORMATION

Welcome to Our Practice

Thank you for selecting Pacific Maxillofacial Center. We are committed to providing you with exceptional service in a gentle, caring atmosphere, and will make your visit as pleasant and comfortable as possible. So that we may meet all your healthcare needs, kindly complete these forms. If you have questions, please do not hesitate to ask. It is our privilege to care for you.

Patient Information

Patient: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Name Last Name

Date of Birth: ___/___/___ Nickname/Name you prefer to be called by: _____

Sex: (Male Female) Marital Status: (Single Married Legally-Separated Divorced Widowed)

Social Security #: _____ Driver's License #: _____ (_____)
If Different from Social Security # State

Residence Address: _____
Street Apt. # City State Zipcode

Billing Address: _____
P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Cellular: _____

Employer: _____ Occupation: _____

If Student, Name of School: _____ Status: (Full-Time Part-Time)

Dentist: _____ Medical Doctor(s): _____

Referred By: _____ Are you insured by Kaiser or an HMO? (Yes No)

Person to Contact in Case of Emergency

Emergency Contact: _____ (_____)
First Name Last Name Person's Relation to You

Home Phone: _____ Work Phone: _____ Cellular: _____

Guarantor Information *If self, please skip the following questions in this section.*

Person responsible for paying this account: (Self Spouse Mother Father Other: _____)

Guarantor: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Name Last Name

Date of Birth: ___/___/___ Method of Payment: (Cash Check Debit Visa/Mastercard Amex Discover)

Social Security #: _____ Driver's License #: _____ (_____)
If Different from Social Security # State

Residence Address: _____
Street Apt. # City State Zipcode

Billing Address: _____
P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Cellular: _____

Employer: _____ Occupation: _____

Agreement of Financial Responsibility

I agree to pay in full for all services provided to me (or the named patient). I understand that full payment is required at the time of treatment and any payment plan agreement must be made in writing prior to treatment. If an insurance claim is filed for services, I am responsible for all fees regardless of insurance coverage and will pay any deductible, estimated co-pay, or fee for non-covered services at the time of treatment. For any balance, a statement will be sent by the 5th of the month and is due before the end of the month. I agree to pay finance charges of 18% per annum (1.5% per month, minimum charge of $3.00) on any past due balance until the account has been paid in full. If any collection action is taken, I agree to pay all collection expenses, court costs, and attorney's fees. I will also pay $20 for any returned check, and $50 for any appointment cancelled without 24 hours notice.

_____ _____ _____ _____
Patient's (or Legal Guardian's) Signature Date Guarantor's Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

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.

_____ _____
Patient's (or Legal Guardian's) Signature Date

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HEALTH INSURANCE

Primary Dental Insurance

Insurance Co. & Group: _____ I.D.: _____
Member or Policy # on Insurance Card

Subscriber of Insurance Plan: (Self Spouse Mother Father Other: _____)
If "Self", please skip to the next section.

Subscriber: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Initial Last Name

Mailing Address: _____
Street or P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Employer: _____

Social Security #: _____ Date of Birth: ____/____/____

Secondary Dental Insurance

Insurance Co. & Group: _____ I.D.: _____
Member or Policy # on Insurance Card

Subscriber of Insurance Plan: (Self Spouse Mother Father Other: _____)
If "Self", please skip to the next section.

Subscriber: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Initial Last Name

Mailing Address: _____
Street or P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Employer: _____

Social Security #: _____ Date of Birth: ____/____/____

Primary Medical Insurance

Insurance Co. & Group: _____ I.D.: _____
Member or Policy # on Insurance Card

Subscriber of Insurance Plan: (Self Spouse Mother Father Other: _____)
If "Self", please skip to the next section.

Subscriber: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Initial Last Name

Mailing Address: _____
Street or P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Employer: _____

Social Security #: _____ Date of Birth: ____/____/____

Secondary Medical Insurance

Insurance Co. & Group: _____ I.D.: _____
Member or Policy # on Insurance Card

Subscriber of Insurance Plan: (Self Spouse Mother Father Other: _____)
If "Self", please skip to the next section.

Subscriber: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Initial Last Name

Mailing Address: _____
Street or P.O. Box Apt. # City State Zipcode

Home Phone: _____ Work Phone: _____ Employer: _____

Social Security #: _____ Date of Birth: ____/____/____

Other Insurance Information

Insurance Co.: _____ (Auto Workers Comp) Claim #: _____

Adjustor's Name: _____ Phone: _____ Injury Date: ____/____/____

Release of Records for Insurance

This signature on file is my authorization for the release of my health information, including copies of my dental and medical records, to any health insurance plan or company that provides coverage for me, for the purpose of securing benefits.

Patient's (or Legal Guardian's) Signature Date

Assignment of Insurance Benefits

This signature on file is my authorization for the payment of medical and dental benefits, otherwise payable to me, to Pacific Maxillofacial Center, Inc. directly.

Patient's (or Legal Guardian's) Signature Date

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HEALTH HISTORY

Instructions for Completing this Health History

Although oral & maxillofacial surgeons primarily treat the face, mouth, and jaw, they consider the mutual relationship between the health of these areas and that of the entire body. In order to determine your specific needs and provide you with the best treatment possible, please answer all questions truthfully and to the best of your ability. Your answers will remain confidential.

Patient Information

Patient: (Miss Ms. Mrs. Mr. Dr.) _____
First Name Middle Name Last Name

Date of Birth: ____/____/____ Nickname/Name you prefer to be called by: _____

Age: _____ Sex: (Male Female) Height: _____ Weight: _____

Name of referring dentist or physician: _____

A. Are you in good health? Yes No

B. When was your last physical exam? _____

C. Has there been any change in your health over the past year? Yes No

D. Are you under the care of a physician? If so, for what are you being treated? Yes No

_____

_____

E. Do you have any unhealed/recurrent injuries or inflamed areas or growths? Yes No

F. Have you had any serious illnesses, operations, or hospitalizations? If so, please describe: Yes No

_____

_____

_____

_____

G. Do you have a prosthetic joint/implant? Yes No

H. Have you had a heart valve replacement or vascular graft? Yes No

I. Do you have or have you ever had . . .

Congenital heart disease?	Yes	No	
Damaged heart valves or artificial valves?	Yes	No	
Mitral valve prolapse?	Yes	No	
Heart murmur?	Yes	No	
Rheumatic fever or rheumatic heart disease?	Yes	No	
Irregular heart beat?	Yes	No	
Chest pain/angina?	Yes	No	
Heart surgery?	Yes	No	
Cardiac pacemaker?	Yes	No	
Arteriosclerosis?	Yes	No	
High cholesterol?	Yes	No	
Stroke?	Yes	No	
High blood pressure?	Yes	No	
Low blood pressure?	Yes	No	
Fainting spells?	Yes	No	
Shortness of breath?	Yes	No	
Asthma?	Yes	No	
Bronchitis?	Yes	No	
Emphysema?	Yes	No	
Pneumonia?	Yes	No	
Tuberculosis?	Yes	No	
COPD (Chronic obstructive pulmonary disease)?	Yes	No	

J. Do you have or have you ever had . . .

Chronic cough?	Yes	No	
Chronic sinus problems?	Yes	No	
Snoring or sleep apnea?	Yes	No	
Thyroid disease?	Yes	No	
Kidney disease?	Yes	No	
Are you on dialysis?	Yes	No	
Stomach ulcers or hyperacidity?	Yes	No	
Diabetes?	Yes	No	
Hepatitis, jaundice or liver disease?	Yes	No	
Epilepsy or seizures?	Yes	No	
Mental health problems?	Yes	No	
Nervous or anxiety disorder?	Yes	No	
Abnormal or excessive bleeding?	Yes	No	
Blood transfusion?	Yes	No	
Blood disorder (such as anemia or hemophilia)?	Yes	No	
Arthritis or painful, swollen joints?	Yes	No	
Osteoporosis/Osteopenia?	Yes	No	
Osteonecrosis?	Yes	No	
Cancer or tumors?	Yes	No	
Radiation therapy?	Yes	No	
Chemotherapy?	Yes	No	
Any disease, drugs, or operation that has depressed your immune system?	Yes	No	

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HEALTH HISTORY

K. Do you have or have you ever had . . .

Malignant hyperthermia?	Yes	No	
Glaucoma or eye disease?	Yes	No	
Contact lenses?	Yes	No	
A removable dental appliance?	Yes	No	
Stiff or sore jaw, clicking or popping of jaw, pain near ear, or difficulty opening mouth?	Yes	No	
A history of drug abuse?	Yes	No	
A history of alcohol abuse?	Yes	No	
Do you drink alcohol?	Yes	No	
Do you smoke or use e-cigs?	Yes	No	
Do you chew tobacco?	Yes	No	
Is there any disease or condition not listed that you think the doctor should know about?	Yes	No	
Do you wish to speak to the doctor privately about anything?	Yes	No	

L. Is there a family history of . . .

Cancer?	Yes	No	
Diabetes?	Yes	No	
Heart disease?	Yes	No	
Anesthetic problems?	Yes	No	

M. For Women Only

What is the date of your last menstrual period?			/ /
Is there a possibility of pregnancy?	Yes	No	
If pregnant, what is your estimated delivery date?			/ /
Are you nursing?	Yes	No	
Are you taking birth control pills?	Yes	No	

N. Notice to Women

Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for advice regarding additional methods of birth control.

Medications

O. Are you presently using or taking . . .

Any kind of medication, drug, or pills?	Yes	No
Antibiotics or sulfa drugs?	Yes	No
Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, etc.)?	Yes	No
High blood pressure medicine?	Yes	No
Steroids (Cortisone, Prednisone, etc.)?	Yes	No
Insulin, Glucophage, or oral anti-diabetic drug?	Yes	No
Heart medication (Digitalis, Inderal, Procardia, Nitroglycerin, etc.)?	Yes	No
Marijuana or other recreational drugs?	Yes	No
Have you ever taken diet pills?	Yes	No
Aspirin or ibuprofen?	Yes	No
Any natural product, herbal supplement, or homeopathic remedy?	Yes	No
Have you ever taken bisphosphonates or bone density medications (Actonel, Aredia, Boniva, Prolia, Fosamax, Reclast, Zometa, etc.)?	Yes	No
Have you ever taken tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:	Yes	No

Please list all medications you are now taking:

Allergies

P. Are you allergic or have you had a reaction to . . .

Local anesthetics?	Yes	No
Penicillin?	Yes	No
Other antibiotics?	Yes	No
Sulfa drugs?	Yes	No
Barbiturates, sedatives, or sleeping pills?	Yes	No
Aspirin or ibuprofen?	Yes	No
Codeine or other narcotics?	Yes	No
Latex?	Yes	No
Eggs or egg yolk?	Yes	No
Other allergies or reactions?	Yes	No

Please list all other allergies or reactions:

Signature

I understand the importance of an accurate and complete Health History to assist my doctor in providing the best care possible. I certify that I have read and I understand the questions above. I have had an opportunity to discuss my Health History with my doctor. I agree to inform this office of any change in my health status as soon as possible. I will not hold my doctor or his staff responsible for any errors or omissions that I have made in completion of this form.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date