**Tyler E Nelson, DMD, MD**
(707) 428-5427 Fax: (707) 428-1922
watermanomfs@gmail.com
2801 Waterman Blvd. Ste. #240
Fairfield, CA 94534

Waterman
Oral and Maxillofacial Surgery

# Patient Information

Date: ______________________ Referred by: ________________________________

Patient Name: First ____________________M.I. ____ Last __________________________Date of Birth__________

Social Security ___________-_______-_____________ Male ☐ Female ☐

Home Address ____________________________Apt. # ______ City _____________State ___Zip _____________

Home Phone (____) _____________ Work Phone (___) _____________Cell Phone (_______) ________________

E-mail Address _____________________________________________________________________________

Mailing Address (if different) ______________________________________________________________

If patient is under 18, who do they live with? ____________________________________________________

**In case of emergency**

Name __________________________________ __Relationship _______________________________________________

Phone Number_____________________________________

*****There is a consultation fee*****

I understand that if my account should become delinquent and is submitted to a collection agency or an attorney, that I will pay all reasonable attorney or collection fees including court cost and filing fees as allowed by law. I understand that there is a $175.00 charge for any broken appointments unless I give a full 48 hour business notice of cancellation. I understand that any account balance will be charged an 18% APR. There is a $25.00 delinquent payment fee and a $25.00 return check charge.

**Patient signature:** _____________________________________________________________

*(Parent or legal guardian to sign if under 18)*

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# HEALTH QUESTIONNAIRE

Please circle either Y (yes) or N (no) of the following: Name: ______________________________

| | | |
|---|---|---|
| Y N Anemia | Y N Hay Fever | Y N Heart Trouble |
| Y N Bleeding Disorder | Y N Sinus Problems | Y N Heart Attack, What Year____ |
| Y N HIV/AIDS | Y N Tuberculosis | Y N Heart Murmur |
| Y N Hepatitis Type ____ | Y N Tobacco/Smoking | Y N Mitral Valve Prolapse |
| Y N Liver Disease | Y N Lung Disease | Y N Chest Pain or Angina |
| Y N Alcohol Usage | Y N Colon Disease | Y N Pacemaker/Artificial Valves |
| Y N Drug Usage | Y N Stomach Problems/Ulcers | Y N Frequent Swollen Ankles |
| Y N Cancer Type ____ | Y N Frequent Headaches | Y N Arthritis |
| Y N Chemotherapy | Y N Psychiatric Care | Y N Cortisone Treatment |
| Y N Radiation Therapy | Y N Nervous Disorder | Y N Artificial Joints |
| Y N Head/Neck Radiation | Y N Epilepsy/Seizures | Y N Osteoporosis |
| Y N Diabetes | Y N Fainting | Y N Thyroid Problems |
| Y N Kidney Disease | Y N Glaucoma | Y N Jaw Pain/TMJ |
| Y N Asthma | Y N Low Blood Pressure | Y N Recent Cough or Cold |
| Y N Bronchitis | Y N High Blood Pressure | Y N Unexplained Weight Loss |
| Y N Emphysema | Y N Stroke, What Year _____ | Y N Venereal Disease |
| YN Obstructive Sleep Apnea | Y N Other______________________________ | |

ALLERGY OR SENSITIVITY TO ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| ___Penicillin | ___Aspirin | ___Latex Gloves | ___Barbiturates/Sleeping Pills |
| ___Codeine | ___Iodine | ___Sulfa/Sulfur Drugs | ___Novocaine/Local Anesthetics |
| ___Peanuts | ___Soy | | |

Any additional allergies of medications not listed: ______________________________

Have you ever used Fosomax, Zometa, Aredia, Boniva, Actonel, Skelid, Reclast, Didronel or any other type of Bisphosphonate? ______ If yes, when and for how long? ______________________________

Please circle any of the following if you are currently on or have recently taken: Coumadin, Aspirin, Ibuprofen, Advil, Motrin or Aleve. Please indicate the last time you took this medication: ________________________

Have you been hospitalized within the past 5 years? _____ If yes, Please explain ________________________

______________________________________________________________

Have you been under the care of a physician during the past 2 years? _____ If yes, Please explain___________

______________________________________________________________

Have you been taking medication within the past 2 years? _____ If yes, please list meds

______________________________________________________________

Have you ever had general anesthesia for an operation? _____ If yes, please explain _____________________

______________________________________________________________

Have you or a family member ever had an unfavorable reaction to a general anesthetic? __________________

______________________________________________________________

WOMEN:
Are you pregnant? Y N Are you nursing? Y N Are you taking birth control pills? Y N

**SIGNATURE:**_______________________________________________ DATE:_____________

*(parent or legal guardian to sign if under 18)*

Dr.'s initials __________ Date __________ Time __________

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# INSURANCE INFORMATION

(Please print clearly)

**Patient's Name**: First ____________________________ Last _______________________________

**Primary Dental Insurance**: **Policy Holder's Information:**

Name of Insurance _____________________________ Ins Phone # __________________________

Policy Holder's Name: First ______________________ Last ________________________________

Social Security ___________-_______-_____________ Date of Birth _____/_____/_____

Home Phone (_______) ________ -____________ Work Phone (_______) ________ -___________

Address ____________________________ City _______________ State ___________ Zip _______

Relationship to Patient ___________________________________

**Primary Dental Insurance**: **Policy Holder's Information:**

Name of Insurance _____________________________ Ins Phone # __________________________

Policy Holder's Name: First ______________________ Last ________________________________

Social Security ___________-_______-_____________ Date of Birth _____/_____/_____

Home Phone (_______) ________ -____________ Work Phone (_______) ________ -___________

Address ____________________________ City _______________ State ___________ Zip _______

Relationship to Patient ___________________________________

**What is your Medical Insurance?** ____________________________________________________

**If Kaiser, what is your medical record number?** ________________________________________

We can bill most insurance plans. It is your responsibility to make sure that we receive the correct information. We file insurance claims as a courtesy to our patients. If your insurance company fails to pay on the claim within 60 days for any reason, you will be billed for the full balance. If your insurance pays more than is due, then a refund will be sent to you. Insurance coverage is a contract between you, your employer, and your insurance company and we will not be involved in any disputes regarding deductibles, co-payments, covered charges, etc., other than to supply them with information given to us by you. We also cannot guarantee that the information given to us by your insurance company regarding covered benefits is correct. If your insurance company pays directly to you, we require that the cost of the treatment be paid in full on the day of service.

**YOU ARE ALWAYS RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT REGARDLESS OF WHAT YOUR INSURANCE COMPANY MAY PAY.**

**PATIENT'S SIGNATURE:** _________________________ **DATE:** ______________________

**(Parent or legal guardian to sign, if under 18)**

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# PAYMENT INFORMATION

**PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT:**

☐ Self ☐Spouse ☐Parent ☐Other____________________________

First______________________M.I.______Last:_________________________Phone number_________________

Home address:_________________________________________________________________________________

Apt.#__________City____________________State_____Zip__________________

Social security_____________________________Male ☐ Female ☐ Date of Birth__________________

Mailing address, if different_______________________________________________________________________

| **Primary Dental Insurance** | **Secondary Dental Insurance** |
|---|---|
| Insurance Name_________________________________ | Insurance Name__________________________________ |
| Phone Number__________________________________ | Phone Number___________________________________ |
| Subscriber name First: ___________________________ | Subscriber name First: _____________________________ |
| Last__________________________________________ | Last: _______________________________________ |
| Subscriber SSN/ID______________________________ | Subscriber SSN/ID_______________________________ |
| Date of Birth___________________________________ | Date of Birth_____________________________________ |
| Mailing Address________________________________ | Mailing Address__________________________________ |
| ______________________________________________ | ______________________________________________ |
| Relationship to patient____________________________ | Relationship to patient______________________________ |

**Medical Insurance Company?**______________________________________**If Kaiser MR#**____________________

We can bill most insurance plans. We file insurance claims as a courtesy to our patients. Insurance coverage is a contact between you, your employer, and your insurance company. We will not be involved in any disputes. We also cannot guarantee that the information provided to us by your insurance is correct.

***You are always responsible for the payment of your account regardless of what your insurance may pay.***

Patient signature_____________________________________________________Date____________________

*(Parent or legal guardian if under 18)*

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND MEDICAL RECORDS RELEASE

*You May Refuse to Sign This Acknowledgement*

I, ________________________________________, have received a copy of this office's Notice of Privacy Practices. I authorize Tyler Nelson, D.M.D.,M.D. to release my information to other treating professionals and/or insurance companies.

______________________________________________________________
Please Print Name

______________________________________________________________
Signature

______________________________________________________________
Date

**For Office Use Only**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barrier prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

______________________________________________________________