AUGUSTA UNIVERSITY

Dental College of Georgia
Center for Oral Medicine
Medical History, Health Questionnaire

Patient Name: _____ Date of Birth: _____

Family Doctor: _____ Address: _____

Referring Doctor: _____ Address: _____

Reason for seeing a Doctor in Oral Medicine? _____

To your knowledge, do you now have or have you ever had any of the following:

RESPIRATORY PROBLEMS	YES	NO	NEUROLOGICAL PROBLEMS	YES	NO
Asthma			Stroke/TIA/Mini-stroke		
Tuberculosis			Multiple sclerosis		
Sleep apnea			Epilepsy/Seizure disorder		
Bronchitis/Emphysema			Neuropathy/Neuropathic pain		
HEMATOLOGIC PROBLEMS	**YES**	**NO**	**ENDOCRINE PROBLEMS**	**YES**	**NO**
Anemia			Diabetes		
Sickle cell disease/trait			Thyroid disorder		
HIV disease/AIDS			**OTHER PROBLEMS**	**YES**	**NO**
Bleeding disorders			Renal/Kidney disease or dialysis		
Coumadin/warfarin treatment			Organ transplant		
CARDIOVASCULAR PROBLEMS	**YES**	**NO**	Cancer		
High blood pressure/Hypertension			Radiation treatment		
Angina/Chest pain			Chemotherapy treatment		
Heart attack/Myocardial infarction			Arthritis		
Prosthetic (artificial) heart valve			Used a bisphosphonate medication for osteoporosis or cancer treatment		
Congestive heart failure			Psychiatric treatment		
Heart bypass or stent surgery			**ORAL MEDICINE PROBLEMS**	**YES**	**NO**
GASTROINTESTINAL PROBLEMS	**YES**	**NO**	Dry mouth/Sjogren's Syndrome		
Hepatitis/Jaundice			Mouth ulcers/sores		
Liver disease			TMJ/Temporomandibular disorders		
GERD/Reflux/Ulcers			Fibromyalgia		

SOCIAL HISTORY	YES	NO	
Cigarettes/Cigars/Pipes			Number of years _____
Alcoholic beverages			How much per week? _____
Recreational drugs			What and how often? _____

PREVIOUS HOSPITALIZATIONS?	YES	NO	
Have you ever been hospitalized?			Reason? _____ _____ _____

PLEASE LIST:

MEDICATIONS	ALLERGIES

PAIN ASSESSMENT:

	YES	NO	WHERE
Are you having a problem with pain?			

If yes, please circle your level of pain, with 10 being the worst:

0 1 2 3 4 5 6 7 8 9 10

PATIENT SIGNATURE:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes, I will inform my doctor at my next appointment.

Signature of Patient: _____ **Date:** _____

DOCTOR SIGNATURE:

I have reviewed the patient's medical history.

Signature of Doctor: _____ **Date:** _____

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DIAGNOSTIC SCIENCES
ORAL MEDICINE, ORAL & MAXILLOFACIAL PATHOLOGY, ORAL RADIOLOGY

FINANCIAL POLICY

Our practice is committed to providing you with the finest and most comprehensive care available. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing quality healthcare services to our patients. We believe that full disclosure of our financial policy is important in this relationship. Please read carefully and be sure that any questions you might have are answered before you sign this agreement.

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All co-payments required by your insurance company are due at the time of service, and will be collected at time of check in before you see the doctor. Please provide a copy of your medical insurance card prior to each visit especially if you have a change in insurance companies.

A monthly statement will be sent the month you have been seen prior to your insurance paying. This is to inform you of the charges that were incurred on your visit.

Our office will gladly file health insurance claims on your behalf through the College of Dental Medicine business office. Patient balances remaining after your insurance has processed your claim will be due and payable within thirty (30) days of your insurance company's payment or their notice of non-payment.

We utilize the services of an outside collection agency for past due accounts of 90 days past due.

Monthly payment plans are available for patient balances and may be set up through our business office (this does not include co-payments or deductible amounts that are due for each visit). The minimum monthly payment required is 30% of the total patient balance at the time of the payment plan setup. Charges incurred after a payment plan is established will have to be added to your payment plan and you are responsible for contacting the business office to adjust your payment plan.

Patients with no insurance coverage will be expected to pay the total balance in full at each visit. We offer discounts of 25% to our self-pay patients (patients who have no insurance coverage) who pay in **full at the time of service**.

For your convenience, payments may be made by cash, personal check, money order, MasterCard or Visa.
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I acknowledge that I have read and understand the financial policy of Diagnostic Sciences Department and agree to the terms outlined in this policy. I further understand that I am financially responsible for all amounts not covered by my insurance company.

_____ _____

Signature of Patient or Guarantor Date

College of Dental Medicine
Augusta, GA

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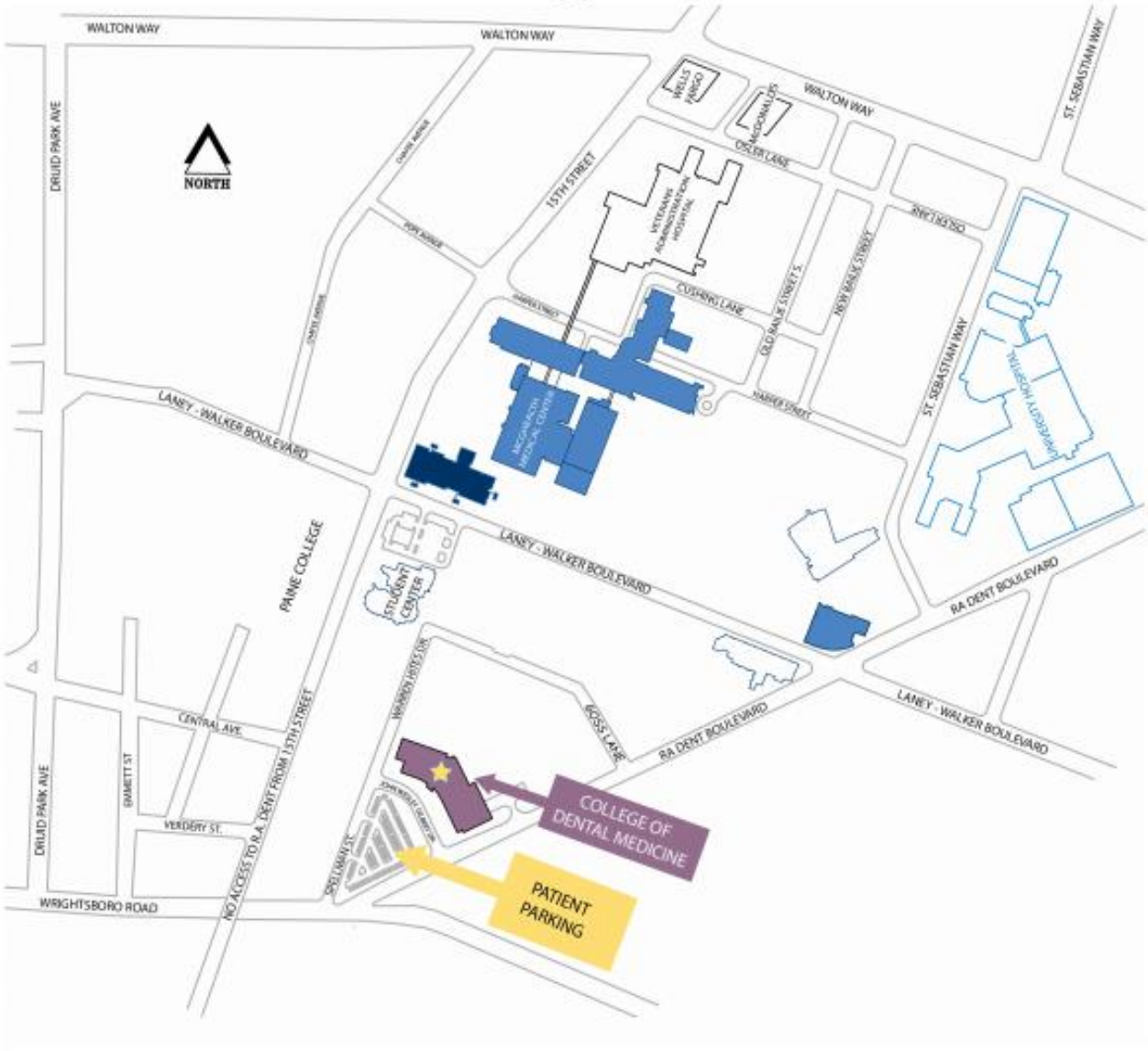

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