Ben F. Tarsitano, D.D.S., M.D.
Diplomate, American Board of
Oral and Maxillofacial Surgery

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640 E. Alvin Dr., Suite C • Salinas, CA 93906 • (831) 443-9300

PATIENT INFORMATION

CHART# ________________

Name ______________________________ S.S.# ______________
Last First Middle

Address ______________________________ Telephone ______________

City ______________________ State ________ Zip ______________

Driver's License # ______________________________

Age __________ Birthdate ______________ Married ☐ Single ☐ Divorced ☐ Widowed ☐

If full time student, school ______________________________

ACCOUNT INFORMATION

Relationship ______________

Person Responsible for Account: Birthdate ______________

Name ______________________________ S.S.# ______________

Address (if different) ______________________________

Previous Address (if less than 1 year) ______________________________

Occupation ______________________ Employer ______________

Business Address ______________________ Phone ______________

Responsible Person's Spouse: Birthdate ______________

Name ______________________ S.S.# ______________

Employer ______________________ Phone ______________

Closest Relative ______________________ Phone ______________

INSURANCE INFORMATION – DENTAL ☐ MEDICAL ☐ MEDI-CAL ☐

Primary

Company ______________________ S.S.# ______________

Group # ______________ Member # ______________ Union # ______________

Secondary

Company ______________________ S.S.# ______________

Group # ______________ Member # ______________ Union # ______________

MISCELLANEOUS INFORMATION

Referred by ______________________________

Patient's Dentist ______________________ Physician ______________

Has any member of your family ever been a patient here? ☐ Yes ☐ No

If so, name of patient ______________________________

Name of person here to drive you home after surgery -

____

FORM 032204 R/01/12 ITEM 8101

Patient's Name ______________________________ Date ______________

Person Filling Out Form
If Different From Patient ______________________________

Name — Relationship

HEALTH QUESTIONNAIRE

	Circle One	
Have you ever had heart trouble?	**Yes**	**No**
Have you ever had rheumatic fever?	**Yes**	**No**
Have you ever had high blood pressure?	**Yes**	**No**
Have any of your relatives died from heart disease or suddenly before age 50?	**Yes**	**No**
Do you sleep with more than one pillow due to breathing problems?	**Yes**	**No**
Have you ever had excessive bleeding after extractions or cuts?	**Yes**	**No**
Have you ever had hepatitis or yellow jaundice?	**Yes**	**No**
Have you ever had a thyroid condition?	**Yes**	**No**
Have you ever had asthma, hay fever, bronchitis or tuberculosis?	**Yes**	**No**
Do you smoke?	**Yes**	**No**
Do you now have a cold or sore throat?	**Yes**	**No**
Have you or any family member ever had diabetes?	**Yes**	**No**
Have you ever had stomach ulcers?	**Yes**	**No**
Are you taking any drugs or medicines at present; have you in the past year?	**Yes**	**No**
Have you been under a doctor's care during the past year?	**Yes**	**No**
Have you ever had a reaction to any drugs or medicines?	**Yes**	**No**
Have you ever tested positive in an HIV virus test?	**Yes**	**No**
Have you ever had X-ray radiation therapy?	**Yes**	**No**
Do you wear contact lenses?	**Yes**	**No**
Do you have a history of glaucoma?	**Yes**	**No**
Have you ever been asleep for surgery?	**Yes**	**No**
Have you had anything to eat or drink in the past 6 hours?	**Yes**	**No**
Adult Females Only - Are you Pregnant?	**Yes**	**No**

Please inquire about any questions which are not understood.

Payment is expected at time of treatment unless prior arrangements have been made.

☐ **Insurance/cash down**

How will you take care of this today? ☐ **Cash** ☐ **Check** ☐ **MasterCard/Visa**

______________________________ Date: ______________

______________________________ Date: ______________

PERMIT FOR OPERATION AND FINANCIAL AGREEMENT

This is my consent for the oral and maxillofacial surgery indicated on the examination chart and any other surgery deemed necessary or advisable as a corollary to the planned operation by Ben F. Tarsitano, D.D.S., M.D. I have been informed of the available alternatives of treatment, the risks of non-treatment and possible complications of surgery, anesthesia and drugs. I understand that there are occasional complications in connection with oral and maxillofacial surgery such as swelling, discomfort, discoloration, vein numbness or tingling of the lip, chin; gum teeth and tongue, which may be permanent, bone fractures and sinus problems, I also agree to the use of local and/or general anesthetic, depending on the judgment of the doctor involved in my case. I realize a perfect result cannot be warranted. The fee is satisfactory.

Signed: ______________________________ Date: ______________

Signed: ______________________________ Date: ______________

Signed: ______________________________ Date: ______________