PATIENT QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS AS PERTAINING TO THE REASON YOU ARE HERE TODAY.

Some oral surgery treatments and procedures are reimbursable through medical insurance.
In an effort to access your medical benefits and gain the maximum reimbursement for you, we need your assessment and details of your physical and mental health.
This information will be used to gain the proper authorization and payment for your procedures.
PLEASE BE DETAILED IN YOUR RESPONSES.

PERSONAL HISTORY

Please tell us your main concern and what you feel has lead you to the dental condition you are in now. How long you have been in your present condition?

MEDICAL HISTORY

Have you tried conservative therapies such as medications or injections? If so, when?

Do you feel that it worked or failed to improve your function?

PAST AND RECENT DENTAL SURGERIES/PROCEDURES:

FUNCTION

How has this condition affected your ability to ORAL FUNCTION, and your GENERAL health and your WELL BEING? Be as detailed as possible.

DIAGNOSIS

Have you been or are you presently diagnosed and being treated for any condition that has affected your physical and mental health?

AUTHORIZATION

I consent to allow the office to share this medical information with the insurance company to help support the medical necessity for my procedures.

Patient Name Printed:____
Patient Signature ____Date:____________________