**David M. Momtaheni, D.M.D.**

**Diplomate American Board of Oral and Maxillofacial Surgery &**

**Oral and Maxillofacial Pathology**

**Rockefeller Center**

**630 Fifth Avenue, Suite 1868, New York, NY 10111 (212) 969-9133**

**Medical Questionnaire Form**

Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ □ Male □ Female

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First) (Middle) (Title)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street) (Apt/Suite) (City) (State) (Zip Code)

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ (Age: \_\_\_\_)

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Closest Relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder D.O.B: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ S.S.N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer each question. Check “yes” or “no”. If in doubt, leave blank**

Are you now under the care of a physician? ( ) Yes ( ) No

If so, what condition(s) are being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized? ( ) Yes ( ) No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous surgery? ( ) Yes ( ) No

If yes, please explain when and why. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? If so, give due date ( ) Yes ( ) No Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking birth control pills? ( ) Yes ( ) No

Have you ever taken prescription medication for weight reduction (Diet Pills)? ( ) Yes ( ) No

If “yes”, did you take any of the following drugs listed below?

\_\_\_\_Fen-Phen \_\_\_\_Pondimin \_\_\_\_\_Redux

If “yes” to any of the above drugs, have you had a medical exam to insure your heart valves were not affected? ( ) Yes ( ) No

Do you currently take Bisphosphonate or have you taken this medication in the past 10 years? ( ) Yes ( ) No

Do you smoke? ( ) Yes ( ) No

If “yes”, how long and how many packs a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? ( ) Yes ( ) No

If “yes” what type and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EAR, NOSE AND THROAT**

Sinus Problem ( ) Yes ( ) No

**NERVOUS SYSTEM**

Stroke ( ) Yes ( ) No

Convulsions/Epilepsy ( ) Yes ( ) No

Psychiatric treatment ( ) Yes ( ) No

**RESPIRATORY**

Tuberculosis ( ) Yes ( ) No

Emphysema ( ) Yes ( ) No

Asthma ( ) Yes ( ) No

Persistent Cough ( ) Yes ( ) No

Snoring ( ) Yes ( ) No

**ENDOCRINE**

Diabetes ( ) Yes ( ) No

Thyroid Condition ( ) Yes ( ) No

**HEART**

Rheumatic Fever ( ) Yes ( ) No

Heart Murmur ( ) Yes ( ) No

Chest Pain ( ) Yes ( ) No

Heart Attack ( ) Yes ( ) No

Shortness of Breath ( ) Yes ( ) No

Swelling of Ankles ( ) Yes ( ) No

High Blood Pressure ( ) Yes ( ) No

Congenital Heart disease ( ) Yes ( ) No

Artificial Heart Valve ( ) Yes ( ) No

Pacemaker ( ) Yes ( ) No

Heart Surgery ( ) Yes ( ) No

**BONE/MUSCLES**

Arthritis/Rheumatism ( ) Yes ( ) No

Artificial Joints ( ) Yes ( ) No

**DIGESTIVE SYSTEM**

(Please circle)

Hepatitis: A, B, C, D, E ( ) Yes ( ) No

Ulcers ( ) Yes ( ) No

**URINARY**

Kidney Disease ( ) Yes ( ) No

Burning during Urination ( ) Yes ( ) No

Bloody Urine ( ) Yes ( ) No

**BLOOD**

Bruise Easily ( ) Yes ( ) No

Anemia ( ) Yes ( ) No

Blood Transfusion ( ) Yes ( ) No

**OTHER**

Cancer ( ) Yes ( ) No

AIDS or HIV ( ) Yes ( ) No

Are you allergic to, or have you ever experienced a reaction to any of the following?

Local Anesthetics (e.g. Novocain) ( ) Yes ( ) No

Barbiturate/sedatives/sleeping pills ( ) Yes ( ) No

Penicillin ( ) Yes ( ) No

Aspirin ( ) Yes ( ) No

Codeine ( ) Yes ( ) No

Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any of the following?

Antibiotics/ Sulfa Drugs ( ) Yes ( ) No

Blood Thinners ( ) Yes ( ) No

Blood Pressure Medication ( ) Yes ( ) No

Thyroid Medication ( ) Yes ( ) No

Cortisone/Steroids ( ) Yes ( ) No

Antihistamines/Allergy Drugs/Cold Remedies ( ) Yes ( ) No

Tranquilizers ( ) Yes ( ) No

Insulin/Other Diabetes Drugs ( ) Yes ( ) No

Nitroglycerin ( ) Yes ( ) No

Aspirin ( ) Yes ( ) No

Bisphosphonate, Such as Fosamax, Boniva ( ) Yes ( ) No

Other Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes to any of the above, list name of medication and dosage below:

Is there any disease, condition or problems not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so,

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

General Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all the preceding answers are true and correct. If I ever have change in my health or change in my medication, I will inform the doctor at the next appointment.

Signature and Date of Patient, Parent, or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that upon my request, I was provided with a copy of the Columbia University Health Sciences Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative If Personal Representative, Personal

 Representative Right to Act

PAYMENT POLICY

This office makes every effort to keep down the cost of our patient’s oral surgical care. The patient can

Help by paying upon completion of each visit. Other arrangements can be made with our office manager

depending upon special circumstances.

This office does not participate with any insurance company; therefore, neither dental/ or medical

insurance are accepted for routine procedures. Please remember that insurance is considered a method

of reimbursing the patient for fees paid at the doctor’s office and is not a substitute for payment.

If the patient would like to contact the Insurance Company to inquire for reimbursement for their visit, it is the patient’s responsibility to fax or mail in the bill given to the patient upon completion of the procedure. Subsequently, if the patient needs any help with his/her claim, the staff is available to provide additional assistance. Thank you for your cooperation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient Signature

**Appointment Cancellation/No-Show Policy Agreement**

**For Doctor Appointments**

1. ***Cancellation/ No Show Policy for Doctor Appointment***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

**If an appointment is not cancelled at least 24 hours in advance, you will be charged a two hundred dollar fee; this will not be covered by your insurance company**.

2. ***Scheduled Appointments***

We understand that delays can happen however, we must try to keep the other patients and doctor on time.

**If a patient is 25 minutes past their scheduled time, we will have to reschedule the appointment.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Signature Patient/Guardian**

**Google Voice Agreement**

We have recently started using a program called **Google Voice** that allows us to send SMS Text Messages directly to your cell phone to remind you of upcoming appointments and cleanings.

We will only use this service if you allow us to. It facilitates our communication with you by getting in touch with you faster.

We will not use this service for any reason unrelated to your dental health care.

The number we will use is (914) 222-0972. You may also call us through this number, as well as text, but the original (212) 969-9133 number is still our primary source of receiving and making calls.

As a reminder, if you select “NO” below, you will still be responsible for covering the $200 charge for “no show” appointments, or appointments cancelled with less than 24 hours notice.

May we phone and/or send text messages to you through Google Voice (914-222-0972) to confirm, schedule, and reschedule appointments?

□YES □ NO

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_