Anthony J. Hornaday, D.D.S.
Oral and Maxillofacial Surgery

Patient Information

Dr. Mr. Mrs. Ms. Miss ____
First Middle Last Nickname

Address: ______________________ City/State: ______________ Zip: __________

Home Tel #: ______________ Work Tel #: ______________ Cell #: ______________

Date of Birth: ____/____/____ Age: ______ Sex: ☐ Male ☐ Female

Soc Sec. #: ______________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: ______________ Occupation: ______________

Name of Your Dentist: ______________ Physician: ______________ Orthodontist: ______________

Who referred you to our office? ☐ Dentist ☐ Physician ☐ Orthodontist ☐ Friend ______________ ☐ Other______________

Have you or any member of your family been a patient in our office before? ☐ Yes ☐ No When? (Year): ______________

Who?: ______________ Relationship to patient: ______________

If patient is a full-time student, name of school: ______________

Emergency Contact: ______________ Daytime phone #: ______________

Relationship to patient: ______________

Billing Information

Responsible party for payment: ______________

Address: ______________ City/State: ______________ Zip: ______________

DOB: ____/____/____ Employer: ______________ Soc Sec #: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

I understand in signing this statement that I am financially responsible to Dr. Anthony J. Hornaday for all fees incurred and all costs of collection: including but not limited to, if necessary, service, collection, collection agency, and attorney fees.

If your insurance company does not pay your claim as expected, the responsible party is obligated for the balance of the account. I hereby authorize the insured's insurance company to pay directly to Dr. Anthony J. Hornaday any and all of the benefits otherwise payable to me or the patient.

Signature of Party Responsible for Payment: ______________ Relationship to Patient: ______________

Print Name: ______________

DENTAL Insurance Coverage Information (If you have additional coverage, please request an additional form)

Primary Dental Insurance Name of Insurance Company: ______________

Subscriber Name: ______________ DOB: ____/____/____ Insured's Daytime Phone #: ______________

Subscriber Address: ______________ Plan ID (If other than SS#): ______________

Subscriber Soc Sec #: ______________ Group #: ______________ Employer Name: ______________

Relationship to Patient: ______________ Insurance Co. Phone: ______________

Insurance Co. Address: ______________

MEDICAL Insurance Coverage Information (If you have additional coverage, please request an additional form)

Primary Medical Insurance Name of Insurance Company: ______________

Subscriber Name: ______________ DOB: ____/____/____ Insured's Daytime Phone #: ______________

Subscriber Address: ______________ Plan ID (If other than SS#): ______________

Subscriber Soc Sec #: ______________ Group #: ______________ Employer Name: ______________

Relationship to Patient: ______________ Insurance Co. Phone: ______________

Insurance Co. Address: ______________

I certify all information is true, correct, and complete and authorize the release of health care information for the purpose of evaluating and administering claims for benefits. I authorize payment of medical/dental benefits to Dr. Hornaday and accept full financial responsibility regardless of insurance coverage.

Signed: ______________ ______________ Date: ______________
Patient or Legal Guardian Signature Relationship to Patient

Print Name: ______________

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Medical History

Patient Name: ____
First Middle Last Nickname

Reason for today's office visit: ____

Height: __________ Weight: ___________ Age: __________

	Yes	No	Notes
Have there been any changes in your general health in the past year?...>	☐	☐	
Are you under the care of a physician?...> For what? ____________	☐	☐	
Have you ever been hospitalized or undergone any surgery?...> Please explain: ____________	☐	☐	

Please indicate if you have ever had any of the following conditions:

	Yes	No	Notes		Yes	No	Notes
Heart Disease				Anemia			
Chest Pain				Bleeding Problems			
Heart Attack				Sickle Cell Anemia			
Bypass				Stomach Ulcer			
Angioplasty				HIV or AIDS			
Heart Murmur				Cancer or Tumors			
Mitral Valve Prolapse				Radiation/Chemotherapy			
Rheumatic Fever				Liver Disease			
High Blood Pressure				Hepatitis or Jaundice			
Artificial Heart Valve				Diabetes			
Pacemaker				Thyroid Disease			
Stroke				Kidney Disease			
Glaucoma				Arthritis			
Asthma				Artificial Joints			
Lung Disease				Seizures (epilepsy)			
Tuberculosis				Elicit (Illegal) Drug Use			
Shortness of Breath				Alcohol/Drug Abuse			
Swollen Ankles				Psychiatric Disorder			

	Yes	No
• Are you currently taking any drugs or medications?...> Please List: ____________	☐	☐
• Have you ever had any adverse reaction to local or general anesthetic?...>	☐	☐
• Are you allergic to anything?...> Please List: ____________	☐	☐
• Have you ever been treated or are you taking medicine for osteoporosis?...>	☐	☐
• Have you ever been prescribed any of the following medications: Fosamax, Aredia, Zometa, Actonel, Boniva?...>	☐	☐
• Is this visit a result of an accident?...> If yes, date of accident and describe: ____________	☐	☐
• Do you smoke?...>	☐	☐
• Women: Are you pregnant?...>	☐	☐
Are you nursing?...>	☐	☐
Do you take birth control?...>	☐	☐
• Do you have any other medical conditions not listed above?...> Please List: ____________	☐	☐

I certify that I have read and understand the above and that the information is correct and accurate. I will not hold Dr. Hornaday or members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signed: ______________________ ______________________ Date: __________
Patient or Legal Guardian Signature Relationship to Patient

Print Name: ____