GREATER PHILADELPHIA
ORAL SURGERY

Mark J. Funt, DMD
Robert Mogyoros, DMD

401 Township Line Road, Suite C
Elkins Park, Pennsylvania 19027
Phone: (215) 379-3382

GENERAL PATIENT INFORMATION

Date: ________________

Thank you for selecting Dr. Mark Funt and Dr. Robert Mogyoros as your oral and maxillofacial surgeons! We will strive to provide you with the best possible care. Please fill out this form completely. If you need any assistance, please ask us – we will be happy to help.

Patient Name: ______________________________________ Nickname: ______________________________

DOB: ____/____/____ Soc. Sec. #: _____________ Home Ph #: _________________ Cell Ph #: _________________

Address: ____ City: _______________ State: ______ Zip: __________

Referred by: ____

Do You Have: ☐ X-ray ☐ Card/Note

RESPONSIBLE PARTY:

Name: ____ Relationship: _____________________________

Address: ____ City: _______________ State: ______ Zip: __________

Employer: _____________________________________ Occupation: ____

EMERGENCY CONTACT:

In the event of an emergency, who should we contact?

Name: ____ Relationship: _____________________________

Ph #: ________________________

INSURANCE INFORMATION:

Primary Medical Insurance Name of Insured: ____

Relationship to Patient: __________________________ Insured DOB: ____/____/_____ Soc. Sec. #: ____________

Occupation: ____ Employer: ____________________________________

Insurance Co.: __________________________________ Group #: ______________ Deductible: ________________

Insurance Co. Address: ____

Primary Dental Insurance Name of Insured: ____

Relationship to Patient: __________________________ Insured DOB: ____/____/_____ Soc. Sec. #: ____________

Occupation: ____ Employer: ____________________________________

Insurance Co.: __________________________________ Group #: ______________ Deductible: ________________

Insurance Co. Address: ____

AUTHORIZATION AND RELEASE:

I authorize the doctor to release any information, including the diagnosis and the record of any treatment or examination rendered to me or any member of my family, to third-party payers and/or other health practitioners. I authorize and request my insurance company(s) to pay all insurance benefits directly to the doctor. I understand that my dental/medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

X____ ____________________

Patient Signature **(Parent if Minor)** Date

COMMENTS: FULL-TIME STUDENTS - PLEASE ADD THE NAME AND ADDRESS OF THE COLLEGE BELOW

____

____

____

GREATER PHILADELPHIA
ORAL SURGERY

Mark J. Funt, DMD
Robert Mogyoros, DMD
401 Township Line Road, Suite C
Elkins Park, Pennsylvania 19027
Phone: (215) 379-3382

HEALTH HISTORY

Name: ______________________________ **Date:** ______________

Weight: ____________ **Height:** ____________ **Age:** ____________

MEDICATIONS: Please list all medications (include aspirin, birth control pills, etc).

____

____

____

(Note for Women: Antibiotics (such as Penicillin, Erythromycin, and others) and some pain medications may alter the effectiveness of birth control pills.

ALLERGIES: Please list all allergies and drug sensitivities.

____

____

____

DO YOU HAVE OR HAVE YOU EVER HAD: (Check all that apply)

- ☐ Heart Trouble
- ☐ Chest Pain (Angina)
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Swollen Ankles
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Breathing Disorders
- ☐ Emphysema
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Stomach Disorder
- ☐ Hepatitis
- ☐ Viral Immune Disorders
- ☐ Blood Disorders
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Thyroid Disorder
- ☐ Delayed Healing
- ☐ Past Surgeries
- ☐ Smoke Tobacco

  If so, how much? ______________

If any boxes above are checked, please explain in more detail: ______________________________

____

____

____

I certify that the above information is correct to the best of my capabilities to answer. I also understand that I will be responsible for all fees incurred that are not paid by my insurance companies.

Patient Signature: ______________________________