James G Loeser, DDS, MD
ORAL, MAXILLOFACIAL & IMPLANT SURGERY

File # _____

1580 N Northwest Hwy, Suite 300
Park Ridge, IL 60068

All personal information is held in the strictest confidence.

Date _____

Patient Information:

First Name: _____ MI: __ Last Name: _____ Title: _____

Nickname _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: ___ SS#: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Student: _____ School: _____

Have you been a patient of our practice before: _____

Insurance Information (if different from above)**:**

Who is responsible for this account: _____

First Name: _____ MI: __ Last Name: _____ Title: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: ___ SS#: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse Name: _____ Occupation: _____

Referral Information:

Who referred you to our office: _____

General Dentist: _____ Phone: _____

Orthodontist: _____ Phone: _____

Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

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Medical History: Do you have or have you had any of the following?

Heart attack	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No	Autoimmune disorders	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Immune system deficiency	☐ Yes	☐ No
COPD / emphysema	☐ Yes	☐ No	Drug / alcohol addiction	☐ Yes	☐ No
Kidnery failure / dialysis	☐ Yes	☐ No	Anxiety / psychiatric care	☐ Yes	☐ No
Hepatitis / liver disease	☐ Yes	☐ No	Painful / clicking jaw joints	☐ Yes	☐ No
Stroke / CVA	☐ Yes	☐ No	Cancer / malignancy	☐ Yes	☐ No
Blood clots / DVT / PE	☐ Yes	☐ No			
Seizures / epilepsy	☐ Yes	☐ No	Site: _____		
Asthma	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Respitory Illness / COVID	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No

☐ Yes ☐ No Have you ever taken drugs to treat osteoporosis (Boniva, Fosamax, Actonel, Zometa, Aredia)?

☐ Yes ☐ No Blood thinners (Coumadin, Plavix, Aspirin, Eliquis, Pradaxa, Xarelto)?

☐ Yes ☐ No Smoke or vape? Quit? ☐ Yes ☐ No Year: _____

☐ Yes ☐ No Artificial joints (hip / knee / shoulder) ?

☐ Yes ☐ No Artificial heart valve?

☐ Yes ☐ No Pregnant or breastfeeding?

Illnesses or conditions not listed above:

Please list all current medications : (attach a sheet for long lists)

Please list all previous surgeries:

Please list any allergies (e.g. medicines, latex):

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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File # _____

Primary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Primary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Secondary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Secondary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

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MEDICAL INFORMATION RELEASE FORM
(HIPAA FORM)

Name: _____ Birth Date: _____

Authorize:

☐ I authorize the release of information including the history, examination, diagnosis, and treatment rendered to me, and claims and billing information. This information may be released to:

- ☐ Spouse: _____
- ☐ Parents: _____
- ☐ Children: _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: ☐ Cell ☐ Home

If unable to reach me:

- ☐ Leave a detailed message
- ☐ Leave a message asking me to return your call
- ☐ Other: _____

Signature of patient / legal representative: _____ **Date:** _____