UT★OMS Oral and Maxillofacial Surgeons

a part of UT★Dentists

# WELCOME TO UT-OMS

We want to welcome you as a patient, and in an effort to reach your ultimate satisfaction, we want to give you options for reaching our staff members and doctors. Please be aware that our phone lines remain busy, so make note of other ways to communicate your issues & concerns. **The best way to communicate with all of our doctors and staff members would be through the email address below.**

Thank you

| | |
|---|---|
| Main Phone Number | 713-500-4000 |
| Fax Number | 713-793-1229 |
| E Mail Address | ut.oms@uth.tmc.edu |
| Patient Portal | MyUTHealth.org |

**DOCTORS:**

| | | |
|---|---|---|
| Dr. Kamal Busaidy | Dr. Nagi Demian | Dr. Jose Marchena |
| Dr. James Melville | Dr. Issa Hanna | Dr. Jonathan Shum |
| Dr. Nadarajah Vigneswaran | Dr. Craig Pearl | Dr. Mark Wong |
| Dr. Alfredo Arribas | Dr. Timothy Woernley | Dr. Christopher Daniel |

**DENTAL ASSISTANTS**

| | | | |
|---|---|---|---|
| Rosa | Rosie | Candy | Judith |

**ADMINISTRATIVE STAFF**

| | | | |
|---|---|---|---|
| Cecilia | Melissa | Shymira | Darlene |
| Courtney | Dena | Helen | Ambreia |

## UT Oral & Maxillofacial Surgery- Medical Questionnaire

Date:_____
Last Name:_____ First:_____ MI:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone: _____ Cell/Page/Other: _____
SS#:_____ DOB:_____ Age: _____ Marital Status: _____

Emergency contact- Name:_____ Relationship:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone: _____ Cell/Page/Other: _____

Referred By- Name: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Primary Care Physician-Name: _____
Address:_____ City:_____ State: _____ Zip:_____
Phone:_____ Fax:_____

What is the reason for your visit with us? _____

**Do you have or have you had any of the following? Check if Yes**

**GENERAL**
_____ Recent Weight Change
_____ Weakness
_____ Fatigue
_____ Fever
_____ Cancer
_____ HIV infection / AIDS

**SKIN**
_____ Rashes

**HEAD**
_____ Headache
_____ Head injury

**EYES**
_____ Vision problems
_____ Double vision
_____ Glaucoma

**EARS**
_____ Hearing problems
_____ Ringing in the ears
_____ Earaches
_____ Ear infections

**NOSE AND SINUSES**
_____ Stuffiness
_____ Discharge
_____ Hay fever
_____ Nose bleeds
_____ Sinus trouble

**MOUTH and THROAT**
_____ Bleeding Gums
_____ Frequent sore throats
_____ Hoarseness

**NECK**
_____ Lumps in the Neck
_____ "Swollen Glands"
_____ Goiter

**RESPIRATORY**
_____ Cough
_____ Sputum
_____ coughing blood
_____ Wheezing
_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis

**CARDIOVASVULAR**
_____ Heart trouble
_____ High Blood Pressure
_____ Rheumatic Fever
_____ Heart Murmur
_____ Mitral Valve Prolapse
_____ Chest Pain or discomfort
_____ Angina
_____ Heart Attack
_____ Palp1tations
_____ Pacemaker
_____ Difficulty Breathing
_____ Swollen ankles
_____ Heart Failure
_____ Heart Surgery
_____ Stroke
_____ Thrombophlebitis

**GASTROINTESTINAL**
_____ Trouble swallowing
_____ Heartburn
_____ Nausea / Vomiting
_____ Vomiting blood
_____ Diarrhea
_____ Abdominal pain
_____ Jaundice
_____ Liver trouble
_____ Hepatitis

**URINARY**
_____ Kidney Problems/ Dialysis
_____ Difficulty urinating
_____ Urinary infections
_____ Stones

**MUSCULOSKELETAL**
_____ Muscle or joint pain
_____Stiffness
_____ Arthritis
_____ Gout
_____ Joint Implants

**NEUROLOGIC**
_____ Fainting
_____Seizures/ epilepsy
_____ Weakness
_____ Paralysis
_____ Numbness
_____ Tingling

**HEMATOLOGICAL**
_____ Anemia
_____ Bleeding Problems
_____ Blood Disorders

**ENDOCRINE**
_____ Diabetes
_____ Thyroid Disorders
_____ Other Hormonal Problems
_____ Steroids Last 2 Yrs

**PSYCHIATRIC**
_____ Nervousness
_____ Tension
_____ Depression
_____ Anxiety

Is there anything you would like to discuss in private with the doctor?_____

**PLEASE COMPLETE BACK**

Have you had any diseases, medical problems, or hospitalizations in the last two years? Please list:

_____

_____

List all surgeries you have had in the past- Include dates:

_____

_____

_____

_____

List all medications you are taking now:

_____

_____

Are you allergic to dental anesthetics?_____

Are you allergic to any other medications?_____

Do you use alcohol or tobacco products?_____

Do you use recreational drugs?_____

Please list any other medical problems you have or have had in the past:

_____

_____

**FOR WOMEN ONLY**

Are you using Oral Contraceptives (birth control pills)? YES☐ NO☐

There is evidence that certain antibiotics can reduce the efficacy of birth control pills. Patients taking antibiotics should use alternate methods of birth control to prevent pregnancy.

Are you currently trying to get pregnant? YES☐ NO☐

Surgery or anesthesia during early pregnancy can have serious consequences, including potential harm to the fetus.

Would you like to consult your physician to rule out pregnancy prior to having oral surgery? YES☐ NO☐

I have answered all the above to the best of my ability.

_____ _____

Patient's Signature Date

**Patient Photograph Release**

I give permission to UT Oral & Maxillofacial Surgery and its authorized representatives to take and reproduce photographs in connection with my diagnosis, care and treatment, including surgical procedures, and authorize that such photographs may be part of the doctor's files or medical record. I also authorize the doctor to use and publish these photographs at his or her discretion for educational and research purposes, provided that I shall not be identified by name in any such publication use.

_____ _____

Patient's Signature Date

UTHealth
The University of Texas
Health Science Center at Houston

**School of Dentistry**
**Health Information Management**
7500 Cambridge Street, Suite 1332
Houston, TX 77054
Phone: (713) 486-4254 Fax: (713) 486-4322

# Authorization for Verbal Disclosure of Protected Health Information (PHI)

Original document scanned in UTHealth School of Dentistry EHR patient's record.

## Patient Information

Name: _____

DOB: _____ Telephone#: _____ EHR#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

## Authority to Disclose Protected Health Information

☐ Yes, I hereby authorize UTHealth School of Dentistry to discuss my protected health information with the following designated family members or others involved in my dental care. This information may pertain to my health history, dental treatments, financial obligations, and/or appointments (including scheduling).

1. _____
   Name (Please Print) Telephone Relationship to Patient
2. _____
   Name (Please Print) Telephone Relationship to Patient
3. _____
   Name (Please Print) Telephone Relationship to Patient
4. _____
   Name (Please Print) Telephone Relationship to Patient

☐ No, I do **NOT** want my Protected Health Information shared with any individuals.

## Authorization Notice and Signature

1. I understand that disclosure of PHI under this document is limited to verbal discussions with UTHealth School of Dentistry personnel. This document does not permit release of any written health information to the individuals listed above with the exception of post-op instructions.
2. I understand discussions will be permitted as listed above unless restrictions are specified here:

   _____.
3. This authorization is valid until otherwise revoked.
4. I understand that I may withdraw this authorization at any time by submitting a written, dated request and that such revocation does not affect action that already has been taken based on this authorization.
5. I understand that to the extent any recipient of this information, as identified above, is not a "covered entity," any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may be not protected by federal or Texas privacy laws.

_____ _____ _____
Patient or Guardian/Legal representative Date Relationship, if NOT the Patient

UTHealth | School of Dentistry
The University of Texas
Health Science Center at Houston

The University of Texas Health Science Center at Houston School of Dentistry is requesting your social security number in order to expedite submission of claims third party payers. The university will not disclose an individual's social security number without the consent of the individual to anyone outside the University except as mandated by law. Providing your social security number will minimize administrative delays associated with the requested service.

| Name of Patient | Signature of Patient, Parent, or Legal Guardian | Date |
|---|---|---|

*See next page >>>*

UT★OMS Oral and Maxillofacial Surgeons

# Consent for Treatment and Acknowledgement of Risk

The recent coronavirus pandemic has changed the way medicine is practiced. Treatment in an infected patient may involve new and unknown risk. For that reason, we will not proceed if you the patient, or any of the providers, are either positive for COVID or showing symptoms of infection. You may be asked to take a COVID test shortly before the procedure.

In addition, there is a risk of infection in coming to a clinical setting, although precautions are in place to prevent infection in the clinic and waiting areas.

I, _____ , fully understand the risks outlined above and wish to proceed.
[Patient Name]

Patient signature:

Date:

Physician signature: