WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

Today's Date_____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name_____ M.I._____ Last Name_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Social Security Number_____

Street_____ Apt._____ City_____ State_____ Zip_____

Home Tel.(_____)_____ Cell.(_____)_____ E-mail_____

Did you find our practice online? ❑ Yes ❑ No Referred By_____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist_____ (FIRST NAME) _____ (LAST NAME) Orthodontist_____ (FIRST NAME) _____ (LAST NAME)

Medical Dr._____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy_____ Tel.(_____)_____

Driver's Lic.#_____ Nearest relative not living with you_____ (FIRST NAME) _____ (LAST NAME) Tel.(_____)_____

Employer_____ Bus. Tel.(_____)_____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact_____ Tel.(_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other_____

Name_____ (FIRST NAME) _____ (LAST NAME) S.S.#_____ Birth Date_____ Age_____

Tel.(_____)_____ Cell.(_____)_____ E-mail_____

Street_____ Apt._____ City_____ State_____ Zip_____

Driver's Lic.#_____ Employer_____ Bus. Tel.(_____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name_____ (FIRST NAME) _____ (LAST NAME) Relation_____ S.S.#_____ Birth Date_____

Street_____ Apt._____ City_____ State_____ Zip_____

Tel.(_____)_____ Employer_____ Bus. Tel.(_____)_____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address_____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer_____

Bus. Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____)_____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____)_____ Group Name_____

Group #_____ Insured Party_____ (FIRST NAME) _____ (LAST NAME)

Relation_____ Birth Date_____ Sex: ❑ M ❑ F

S.S. #_____ Tel.(_____)_____

Address_____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

STOP! DETACH THIS TOP SHEET ONLY, AND BRING IT TO THE FRONT DESK BEFORE PROCEEDING.

WELCOME TO OUR PRACTICE

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age ____ Social Security Number _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Home Tel.(____) _____ Cell.(____) _____ E-mail _____

Did you find our practice online? ❑ Yes ❑ No Referred By _____ (FIRST NAME) _____ (LAST NAME)

Have you ever been a patient of our practice? ❑ Yes ❑ No Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME)

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(____) _____

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(____) _____

Employer _____ Bus. Tel.(____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age ____

Tel.(____) _____ Cell. (____) _____ E-mail _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Driver's Lic.# _____ Employer _____ Bus. Tel.(____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. ____ City _____ State ____ Zip ____

Tel. (____) _____ Employer _____ Bus. Tel.(____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

SECONDARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

ARE YOU NOW TAKING:	YES	NO	NOTES
73. Any kind of medication, drug, pills?			
74. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?			
75. Have you ever taken diet pills?			
76. Any natural product, herbal supplement or homeopathic remedy?			
77. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Prolia, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Xgeva, or Evista in the past 12 years?			

78. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

79. If you are under the care of a physician for pain management, or recovering from drug addiction, select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other
Treating doctor:

80. Please list any medications you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
81. Local anesthetic (numbing meds.)?			
82. Penicillin?			
83. Other antibiotics?			
84. Sulfa drugs?			
85. Sodium pentothal / Valium /other tranquilizers?			
86. Aspirin?			
87. Amoxicillin?			
88. Codeine or other narcotics?			
89. Latex?			
90. Soy?			
91. Eggs / yolk?			
92. Sulfites?			
93. Do you have any known allergies?			

94. Please list any allergies other than drug allergies:

95. Please list any other medication or antibiotic you are allergic to:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Name of attorney / adjustor _____

Tel (____) _____ Claim number _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date** X _____ **Reviewed by** X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)* X _____ **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

❑ I permit the office to communicate with me via text message on my cell phone.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Witness** X _____ **Doctor** X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)* X _____ **Date**

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oral and maxillofacial surgery

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I hereby authorize Dakota Valley Oral and Maxillofacial Surgery to discuss and/or share my protected health information as indicated below to the following people:

[ ] Appointment Dates, Times & Location [ ] Billing Information [ ] Health Information [ ] All of the Above

Name_____ Relationship_____

Name_____ Relationship_____

*If you wish to release your medical records from Dakota Valley Oral and Maxillofacial Surgery, please complete a separate Medical Records Release form.

_____ _____

Signature of Patient , Parent, or Guardian Date

_____

Relationship to Patient (if other than patient)

in front of _____

Signature of Witness – Practice Representative

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FINANCIAL AGREEMENT FOR ORAL AND MAXILLOFACIAL SURGERY PROCEDURES

The following information is provided to you in order to avoid any misunderstandings or disagreements concerning payments for professional services.

- Payment **in full** is due on the date of service, unless you have active insurance with benefits remaining that are applicable to the procedures being performed.
- We must have your insurance information in our office 1 week prior to your appointment in order to confirm your insurance status and benefits available. If we do not have the information necessary for confirmation of benefits, payment **in full** will be due on the date of service.
- If you have active insurance with benefits remaining, your down-payment will be due on the date of service. Down-payments collected on date of service are only an **estimate** of your responsibility. Final patient responsibility will be determined when all applicable insurance has paid.
- When you provide a check as payment, you are authorizing us to use information from your check to make a one-time electronic funds transfer from your bank account or to process the payment as a check transaction.
- **All balances remaining open at 60 days are due in full, regardless of pending insurance claims.**
- Patient accounts with balances open at 90 days will be subject to more aggressive collection efforts. Accounts 90 days and older will accrue a finance charge of 1.5% per month, and all charges incurred in the recovery of a delinquent account will be added to the patient's account balance. These charges include, but are not limited to, collection fees, legal fees and court costs. Recovery costs can increase a patient's balance by as much as 40%
- Please notify us immediately if a mistake appears on your statement.

We will file your insurance claims in order to help you achieve your maximum allowable benefits, but we cannot extend credit beyond 60 days in any case. If you believe that you will need longer than 60 days to pay your charges, we offer a number of third-party payment plans for which you may be eligible.

Our practice strives to establish a good doctor-patient relationship, and we understand that the collections experience is an important part of that relationship. This good relationship is only possible with open and clear communication. The staff of Dakota Valley Oral and Maxillofacial Surgery has been instructed to make every effort to help you understand your balance.

Please sign below indicating that you have read and understand this agreement.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Relationship of Patient (if other than patient)

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INSURANCE NOTICE

As a service to you, we will file your claim with your dental and medical insurance carriers. However, there are several factors that we need to call to your attention:

1. We cannot know, and do not hold ourselves out to you as knowing, the intricacies of the 1500+ insurance plans for which we file claims.

2. If you need to know what portions of your service will be covered by insurance, we advise you to call your insurance company and to read your benefits manual prior to your date of service. If that does not answer enough of your questions, we will be happy to schedule a consultation and submit a pre-estimate.

3. Even with a pre-estimate, there are procedures our surgeons cannot anticipate until they begin the surgery. Thus, an actual claim may differ from the pre-estimate, and so may the benefits that are paid.

4. Fees not covered by insurance are to be paid by you 100%. The most common procedures not covered by insurance companies are:

General Anesthesia	**($434* - $700*)**
CT Scan	**($395* - $425*)**
Panorex	**($130* - $170*)**
Office Visit	**($73* - $150*)**

* all listed fees are approximate
Non-covered fees are not limited to those listed above.

5. If you request that we submit your claim to more than one insurance company, it frequently happens that both insurance companies pay as primary. (This occurs despite our efforts to request they coordinate benefits.) This may create a large credit balance in your account, and we will need to re-submit the claim to each so that they can coordinate benefits.

   If an overpayment occurs, we are unable to refund any of your down-payment until the insurance companies determine which is the primary provider, and the secondary provider(s) requests their refund. For us to issue your refund before this point may result in essentially giving you money that may belong to the insurance company.

   In our experience, this process can take as long as 3-5 months. We ask for your patience during this time.

   It is also possible that only one insurance company will pay benefits on a claim (non-duplication clause).

_____ _____

Patient or Responsible Party Date

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit?_____

		Yes	No
1.	***Height***_____***Weight***_____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated?_____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe_____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where_____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where***_____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			
37. Gallbladder trouble?			
38. Fainting spells?			

HAVE YOU EVER HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Acid reflux?			
51. Stomach / GI troubles / ulcers / IBS / colitis?			
52. COVID-19?			
53. Contagious diseases?			
54. Sexually transmitted diseases?			
55. Problems with immune system?			
56. Autoimmune disease?			
57. Delay in healing?			
58. A tumor or growth?			
59. Cancer / radiation therapy / chemotherapy?			
60. Chronic fatigue / night sweats?			
61. Are you on a diet?			
62. A history of alcohol abuse?			
63. A history of marijuana or other drug use?			
64. Contact lenses?			
65. Eye disease / glaucoma?			
66. Mental health problems / anxiety / depression?			
67. A removable dental appliance?			
68. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 69–72)*

69. Is there a possibility of pregnancy? ..... ❑ Yes ❑ No
70. Expected delivery date?_____
71. Are you nursing? ..... ❑ Yes ❑ No
72. Are you taking birth control pills? ..... ❑ Yes ❑ No

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*