

# — PATIENT INFORMATION SHEET —

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Married  Divorced  Legally Separated  Widow  Single \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Tel.: ( \_\_\_\_\_ ) \_\_\_\_\_ Bus. Tel.: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell #: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

Nearest relative not living with you (name, address & phone): \_\_\_\_\_

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Referred by:  Dentist  Friend  Relative  Phone Book  Self

**Student:**  Full Time  Part Time **School/College** \_\_\_\_\_

Who will be responsible for your account if minor?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	Soc.Sec. # _____
<b>MUST FILL OUT</b>			
	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Single
Name: _____	Home Tel.: ( _____ ) _____		
Street/City/State/Zip: _____	Date of Birth _____		
Employer: _____	Tel.: ( _____ ) _____		

<p><b><u>DENTAL INSURANCE</u></b></p> <p>_____</p> <p><b>POLICY HOLDER: (If different than patient)</b></p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____ Phone: ( _____ ) _____</p> <p>*Date of Birth: _____</p> <p>*Social Security No.: _____</p> <p><b>EMPLOYER OF POLICY HOLDER</b></p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Your occupation: _____</p>
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<p><b><u>MEDICAL INSURANCE</u></b></p> <p>_____</p> <p><b>POLICY HOLDER: (If different than patient)</b></p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____ Phone: ( _____ ) _____</p> <p>*Date of Birth: _____</p> <p>*Social Security No.: _____</p> <p><b>EMPLOYER OF POLICY HOLDER</b></p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____</p> <p>State: _____ Zip: _____</p> <p>Your occupation: _____</p>
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## — HEALTH HISTORY —

To our patients:

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication 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.

Are you in good health?  Yes  No      Height \_\_\_\_\_ Weight \_\_\_\_\_

Have there been any changes in your general health in the past year?  Yes  No

Are you under the care of a physician?  Yes  No      Date of last visit \_\_\_\_\_

If so, for what are you being treated? \_\_\_\_\_

Have you had any illness, **operation** or been hospitalized in the past?  Yes  No

If so, for what and when \_\_\_\_\_

Do you have unhealed injuries or inflamed areas  
in or around your mouth, growth or sore spots in your mouth?  Yes  No

HAVE YOU HAD OR DO YOU CURRENTLY HAVE . . .		Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE/USE . . .		Yes	No	NOTES
1	Joint replacement?				27	Kidney trouble?			
2	Rheumatic fever?				28	Are you on dialysis?			
3	Jaundice, hepatitis or liver disease?				29	Gallbladder trouble?			
4	Contagious diseases?				30	Fainting spells?			
5	Sexually transmitted diseases?				31	Problems of the immune system?			
6	AIDS or HIV infection?				32	Infectious mononucleosis?			
7	Damaged heart valves/ mitral valve prolapse?				33	Convulsions, epilepsy?			
8	Heart murmur?				34	Swollen ankles, arthritis or joint disease?			
9	High Blood pressure?				35	Stomach ulcers?			
10	Low blood pressure?				36	Stroke?			
11	Chest pain angina?				37	Thyroid trouble?			
12	Heart attack(s)?				38	Diabetes?			
13	Irregular heart beat?				39	Low blood sugar?			
14	Cardiac pacemaker?				40	A tumor or growth?			
15	Heart surgery?				41	Mental health problems?			
16	Bronchitis, chronic cough?				42	Removable dental appliances?			
17	Asthma?				43	Are you on a diet?			
18	Hayfever/Sinus problems?				44	Drugs?			
19	Tuberculosis?				45	Alcohol beverages?			
20	Emphysema?				46	Contact Lenses?			
21	Difficulty breathing?				47	Eye disease/glaucoma?			
22	Any other lung trouble?				48	X-Ray treatment/chemotherapy?			
23	Do you smoke?				49	Blood transfusion?			
24	Blood disorder such as anemia?				50	Pain & clicking of jaws when eating?			
25	Bruise easily?				51	Malignant Hyperthermia?			
26	Bleeding tendency (abnormal bleed?)				52				

MEDICATION	YES	NO
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**ARE YOU NOW TAKING ANY KIND OF MEDICINE, DRUG OR PILLS FOR ANY PURPOSE?**

- |                                        |                          |                          |
|----------------------------------------|--------------------------|--------------------------|
| Blood Thinners? .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Tranquillizers? .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone? .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Other medications? (Please list) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
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**ALLERGIES**

**ARE YOU ALLERGIC TO OR HAD A REACTION TO:**

- |                                                   |                          |                          |
|---------------------------------------------------|--------------------------|--------------------------|
| Latex? .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical tape or band-aids? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthesia? .....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin, amoxicillin or any antibiotics? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine or other narcotics? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa drugs? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Other medications? .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
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**IS THERE ANY CONDITION CONCERNING YOUR HEALTH OR FAMILY'S ANESTHETIC HISTORY THAT THE DOCTOR SHOULD BE TOLD?**

- |                                                        |                          |                          |
|--------------------------------------------------------|--------------------------|--------------------------|
| <b>WOMEN:</b>                                          |                          |                          |
| Is there a possibility that you may be pregnant? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Estimated delivery date? .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing? .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills .....               | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have read and understand the 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 surgeon, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Operating Dr. \_\_\_\_\_ Date: \_\_\_\_\_