FRED A. LOE, DDS, PA
Oral & Maxillofacial Surgery

## Patient Information

Patient Last Name: _____ First: _____ M.I.: _____

Street Address: _____ Apt: _____ City: _____ State: ____ Zip: _____

Home Phone: (____)_____-_____ | Work Phone: (____)_____-_____ | Cell Phone: (____)_____-_____

Sex: _____ | Birthdate: _____ | SSN: _____-_____-_____

Employment Status (*check one*): ___Full-time | ___Part-time | ___Self -employed | ___Unemployed | ___Retired | ___Active Duty

Patient Employer: _____ | Occupation: _____

Patient Work Address: _____

Relationship Status (*check one*): ___Single | ___Divorced | ___Married (*if married, please fill out spouse's information*)

Spouse's Name: _____ | Birthdate: _____ | SSN: _____-_____-_____

Spouse's Employer: _____ | Occupation: _____ | Work Phone: _____

Spouse's Work Address: _____

Student Status (*check one*): ___Full-time | ___Part-time | ___Not a Student

Person Financially Responsible (*If patient single or a minor*): _____ | Birthdate: _____

SSN: _____-_____-_____ | Home Phone: (____)_____-_____

Billing Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ | Occupation: _____ | Work Phone: (____)_____-_____

Work Address: _____

Emergency Contact Name: _____ | Patient Relationship: _____ | Phone: (____)_____-_____

Current General Dentist: _____ | Phone Number: (____)_____-_____

Current Primary Physician: _____ | Phone Number: (____)_____-_____

How did you find out about our practice? (e.g. website, ad, referral, etc) _____

Referred by: _____

Have you or anyone you known ever been a patient of our practice? _____

## Insurance Information

Do you have Primary Medical Insurance(*check one*)? ___Yes | ___No

Primary Insurance Name: _____ | Group #: _____ | ID #: _____

Policyholder Name: _____ | SSN: _____-_____-_____ | Birthdate: _____

Patient Relationship: _____ | Employer: _____

Do you have Secondary Medical Insurance(*check one*)? ___Yes | ___No | Secondary Insurance Name: _____

Policy Holder Name: _____ | Group #: _____ | ID #: _____

Do you have Primary Dental Insurance(*check one*)? ___Yes | ___No

Primary Insurance Name: _____ | Group #: _____ | ID #: _____

Policyholder Name: _____ | SSN: _____-_____-_____ | Birthdate: _____

Patient Relationship: _____ | Employer: _____

Do you have Secondary Dental Insurance(*check one*)? ___Yes | ___No | Secondary Insurance Name: _____

Policy Holder Name: _____ | Group #: _____ | ID #: _____

## Health History

**General Health**: Height: _____ Weight: _____

1. Are you in good general health? □ Yes| □ No(*Explain*) _____
_____

2. Any changes to your health in the last 12 months? □ Yes(*Explain*) | □ No _____
_____

3. Do you see a physician regularly? □ Yes | □ No. Date of last exam: _____. Reason for exam: _____

4. Have you had problems with prior dental treatments or procedures? □ Yes(*Explain*) | □ No _____
_____

5. Have you had problems with local or intravenous anesthesia? □ Yes(*Explain*) | □ No _____
_____

**Do you currently have, or have a history of any of the following?**

□ Yes | □ No High Blood Pressure
□ Yes | □ No Rheumatic Fever or Rheumatic Heart Disease
□ Yes | □ No Congenital Heart Defects
□ Yes | □ No Heart Murmurs or Irregular heartbeat
□ Yes | □ No Angina or Coronary Artery Disease
□ Yes | □ No Mitral Valve Prolapse
□ Yes | □ No Open Heart Surgery
□ Yes | □ No Artificial Heart Valves or Heart Pacemaker
□ Yes | □ No Heart Attack
□ Yes | □ No Stroke
□ Yes | □ No Chronic Sinus Problems
□ Yes | □ No Asthma, Emphysema, Bronchitis
□ Yes | □ No Tuberculosis
□ Yes | □ No Seizures, Epilepsy, Fainting
□ Yes | □ No Stomach Issues or Ulcers
□ Yes | □ No Arthritis Joint Pain
□ Yes | □ No Artificial Joint Surgery or Implants
□ Yes | □ No Diabetes or High Blood Sugar
□ Yes | □ No Hepatitis, Jaundice, Liver Disease
□ Yes | □ No Difficulty Breathing or Other Lung Trouble
□ Yes | □ No Chronic Fatigue or Night Sweats
□ Yes | □ No Removable Dental Appliance
□ Yes | □ No Are you on Dialysis

□ Yes | □ No Kidney or Bladder Disease
□ Yes | □ No Thyroid Disease
□ Yes | □ No Hemophiliac, Anemia, Sickle Cell, Bleeding Disorder
□ Yes | □ No Abnormal Bleeding Post-Surgery
□ Yes | □ No Osteoporosis or Osteopenia
□ Yes | □ No Tumors or Cancer
□ Yes | □ No Radiation Treatment or Chemotherapy
□ Yes | □ No Sexually Transmitted Disease
□ Yes | □ No HIV/AIDS or Hepatitis
□ Yes | □ No Treatment for Psychiatric Illness or Issues
□ Yes | □ No Drug Addiction
□ Yes | □ No Excessive Alcohol Use, Abuse or Alcoholism
□ Yes | □ No Developmental Disability
□ Yes | □ No Transplants (Organ, Tissue, etc)
□ Yes | □ No TMD, Clicking, Popping, Pain, Limited Jaw Opening
□ Yes | □ No Injury to Face, Jaws, or Neck
□ Yes | □ No Any Numbness in Face or Mouth
□ Yes | □ No Frequent and/or Severe Headaches
□ Yes | □ No Sleep Apnea
□ Yes | □ No Fainting Spells or Nausea
□ Yes | □ No Glaucoma or Other Eye Disease
□ Yes | □ No Contact Lenses or Glasses
□ Yes | □ No Are you on a Diet

**Have you ever had an adverse or allergic reaction to any of the following?**

□ Yes | □ No Aspirin □ Yes | □ No Vicodin □ Yes | □ No Valium □ Yes | □ No Codeine
□ Yes | □ No Tylenol □ Yes | □ No Penicillin □ Yes | □ No Versed □ Yes | □ No Latex
□ Yes | □ No Clindamycin □ Yes | □ No Amoxicillin □ Yes | □ No Fentanyl □ Yes | □ No Food (*Explain below*)
□ Yes | □ No Local Anesthetic (e.g. Novacaine, Xylocaine etc)

Explanations, other Allergies and/or Drug Reactions: _____
_____

**Do you have a family history of any of the following?**

□ Yes | □ No Cancer □ Yes | □ No Diabetes □ Yes | □ No Heart Disease □ Yes | □ No Anesthetic Problems

**Are you currently taking or have you taken any of the following in the last twelve months?**

□ Yes | □ No Recreational Drugs
□ Yes | □ No Antibiotics
□ Yes | □ No Bisphosphonates (e.g. Fosamax, Boniva, Actonel, etc)

□ Yes | □ No Tobacco (in any form)
□ Yes | □ No Steroids (e.g. Prednisone, etc)
□ Yes | □ No Anticoagulants or Blood Thinners

**Please list or attach all of your current medications.**

_____
_____
_____

**For WOMEN patients ONLY**:
□ Yes | □ No Are you taking Oral Contraceptives?
□ Yes | □ No Are you Nursing?
□ Yes | □ No Are you or could you be pregnant? If Yes, what trimester are you in? _____

**For ALL patients:**
1. Do you have any other diseases or medical problems NOT listed on this form? □ Yes(*Explain*) | □ No _____
_____
_____

2. Have you ever been pre-medicated with an antibiotic for dental treatment or procedures? □ Yes(*Explain why*) | □ No _____
_____
_____

**Physician Information**
The practice of oral and maxillofacial surgery does involve treating the person as a whole. If the surgeon determines that there may be a potentially compromised situation, medical consultation and information may be needed prior to commencement of your treatment.

I authorize this office to contact my physician.

Signature of Patient (Parent or Legal Guardian): _____ Date: _____

Physician's Name: _____ | Phone Number: (____)_____-_____

**Certification**
I hereby certify that I have read and understand this form, and to the best of my knowledge I have answered every question completely and accurately. I will keep my doctor informed of any changes in my health and/or medication. Further, I will not hold my doctor or any other member of his staff responsible for any errors or omissions that I may have made during the completion of this form.

Signature of Patient (Parent or Legal Guardian): _____ Date: _____

Person completing the form if NOT the patient: _____ Relationship to Patient: _____

Signature of Doctor: _____ Date: _____

Signature of Assistant: _____ Date: _____