



### 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?**

- |   |  |
|---|--|
| <input type="checkbox"/> Yes   <input type="checkbox"/> No High Blood Pressure                        | <input type="checkbox"/> Yes   <input type="checkbox"/> No Kidney or Bladder Disease                           |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Rheumatic Fever or Rheumatic Heart Disease | <input type="checkbox"/> Yes   <input type="checkbox"/> No Thyroid Disease                                     |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Congenital Heart Defects                   | <input type="checkbox"/> Yes   <input type="checkbox"/> No Hemophiliac, Anemia, Sickle Cell, Bleeding Disorder |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Heart Murmurs or Irregular heartbeat       | <input type="checkbox"/> Yes   <input type="checkbox"/> No Abnormal Bleeding Post-Surgery                      |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Angina or Coronary Artery Disease          | <input type="checkbox"/> Yes   <input type="checkbox"/> No Osteoporosis or Osteopenia                          |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Mitral Valve Prolapse                      | <input type="checkbox"/> Yes   <input type="checkbox"/> No Tumors or Cancer                                    |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Open Heart Surgery                         | <input type="checkbox"/> Yes   <input type="checkbox"/> No Radiation Treatment or Chemotherapy                 |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Artificial Heart Valves or Heart Pacemaker | <input type="checkbox"/> Yes   <input type="checkbox"/> No Sexually Transmitted Disease                        |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Heart Attack                               | <input type="checkbox"/> Yes   <input type="checkbox"/> No HIV/AIDS or Hepatitis                               |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Stroke                                     | <input type="checkbox"/> Yes   <input type="checkbox"/> No Treatment for Psychiatric Illness or Issues         |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Chronic Sinus Problems                     | <input type="checkbox"/> Yes   <input type="checkbox"/> No Drug Addiction                                      |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Asthma, Emphysema, Bronchitis              | <input type="checkbox"/> Yes   <input type="checkbox"/> No Excessive Alcohol Use, Abuse or Alcoholism          |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Tuberculosis                               | <input type="checkbox"/> Yes   <input type="checkbox"/> No Developmental Disability                            |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Seizures, Epilepsy, Fainting               | <input type="checkbox"/> Yes   <input type="checkbox"/> No Transplants (Organ, Tissue, etc)                    |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Stomach Issues or Ulcers                   | <input type="checkbox"/> Yes   <input type="checkbox"/> No TMD, Clicking, Popping, Pain, Limited Jaw Opening   |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Arthritis Joint Pain                       | <input type="checkbox"/> Yes   <input type="checkbox"/> No Injury to Face, Jaws, or Neck                       |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Artificial Joint Surgery or Implants       | <input type="checkbox"/> Yes   <input type="checkbox"/> No Any Numbness in Face or Mouth                       |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Diabetes or High Blood Sugar               | <input type="checkbox"/> Yes   <input type="checkbox"/> No Frequent and/or Severe Headaches                    |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Hepatitis, Jaundice, Liver Disease         | <input type="checkbox"/> Yes   <input type="checkbox"/> No Sleep Apnea   |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Difficulty Breathing or Other Lung Trouble | <input type="checkbox"/> Yes   <input type="checkbox"/> No Fainting Spells or Nausea                           |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Chronic Fatigue or Night Sweats            | <input type="checkbox"/> Yes   <input type="checkbox"/> No Glaucoma or Other Eye Disease                       |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Removable Dental Appliance                 | <input type="checkbox"/> Yes   <input type="checkbox"/> No Contact Lenses or Glasses                           |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Are you on Dialysis                        | <input type="checkbox"/> Yes   <input type="checkbox"/> No Are you on a Diet                                   |

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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Aspirin     | <input type="checkbox"/> Yes   <input type="checkbox"/> No Vicodin     | <input type="checkbox"/> Yes   <input type="checkbox"/> No Valium   | <input type="checkbox"/> Yes   <input type="checkbox"/> No Codeine              |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Tylenol     | <input type="checkbox"/> Yes   <input type="checkbox"/> No Penicillin  | <input type="checkbox"/> Yes   <input type="checkbox"/> No Versed   | <input type="checkbox"/> Yes   <input type="checkbox"/> No Latex                |
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Clindamycin | <input type="checkbox"/> Yes   <input type="checkbox"/> No Amoxicillin | <input type="checkbox"/> Yes   <input type="checkbox"/> No Fentanyl | <input type="checkbox"/> Yes   <input type="checkbox"/> 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?**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Yes   <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes   <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes   <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes   <input type="checkbox"/> 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 Tobacco (in any form)  
 Yes |  No Antibiotics  Yes |  No Steroids (e.g. Prednisone, etc)  
 Yes |  No Bisphosphonates (e.g. Fosamax, Boniva, Actonel, 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: \_\_\_\_\_