Creekside Oral and Maxillofacial Surgery

PATIENT INFORMATION:

Last________________________________First_____________________________MI________

Date of Birth______/________/_______Age__________ Gender: Male Female

Marital Status: Single Married Divorced Widowed

Social Security # _________- ______ -_________

Street Address____

City, State, & Zip Code ____

Telephone: Home (______) ________-__________

Cell (______) ________-__________ Would you like text confirmation? Yes No

Work (______) ________-__________

Email ___________________________

Emergency Contact_____________________________________Telephone (______) ________-__________

INSURANCE INFORMATION:

Dental Plan Name____________________________________

Subscriber Name_____________________________Subscriber Date of Birth ______/_______/______

Subscriber Social Security # _______ _______ _______ Subscriber Employer __________________

Relationship to patient ______________

Is this your Primary Insurance? Yes No

Do you have any other Dental or Medical Insurance Coverage? Yes No

If yes:

Carrier _________________________

Subscriber Name_____________________________Subscriber Date of Birth ______/_______/______

Subscriber Social Security # _______ _______ _______ Subscriber Employer __________________

Relationship to patient ______________

Health History Form

Patient's Name ______________________________ Date of Birth ____/________/__________

Gender: Male / Female Height: ________ Weight: _________

Your medical history is important to the treatment you will receive. Therefore, it is important that you respond to each question honestly and completely. Please circle your responses.

Please describe your current health: Excellent Good Fair Poor

Please describe the symptoms you are currently having today: ______________________________

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

If yes, please describe: ______________________________

Are you now under a physician's care for a particular problem at this time? Yes No

If yes, why? ______________________________ Date of last physical exam ____/_____/________

Have you ever been hospitalized or had a serious illness? Yes No

If yes, why?______________________________

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Condition			Condition		
Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No

Any disease, chemotherapy or transplant operation? Cancer? Yes No

If so, where? ______________________, and when was the date of your last treatment? ______________

Do you have any other disease, condition or problem <u>not listed above</u> that you think the doctor should know about? Yes No

If yes, please explain: ______________________________

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes?	Yes	No	Relationship ____________	Cancer?	Yes	No	Relationship ____________
Heart disease?	Yes	No	Relationship ____________	Bleeding problems?	Yes	No	Relationship ____________
Tumors?	Yes	No	Relationship ____________	Lung disease?	Yes	No	Relationship ____________

FEMALE PATIENTS

Are you pregnant, or is there any chance you might be pregnant? Yes No

Health History Form

Patient's Name ______________________________ Date of Birth ____/________/__________

MEDICATIONS

Are you using any of the following:

Antibiotics? Yes No

Anticoagulants (blood thinners)? Yes No

Heart drugs? Yes No

Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants Yes No

Prescription pain medication? Yes No

Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Yes No

Insulin or oral anti-diabetic drugs? Yes No

High blood pressure medications? Yes No

Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use. Yes No

____

____

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: ______________________________

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex? Yes No

Food products? Yes No

Sedatives, barbiturates? Yes No

Codeine or other pain killers? Yes No

Aspirin, Motrin, Aleve, or ibuprofen? Yes No

Penicillin or other antibiotics? Yes No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? ____________ Relationship? ______________

Other drug allergies not listed above: ____

SOCIAL HISTORY

Have you ever smoked or chewed tobacco? Yes No If yes, for how long? ______________________________

Have you ever sought professional care or been hospitalized for:

Drug abuse? Yes No

Emotional disorders? Yes No

Alcoholism? Yes No

Do you use:

Alcohol? Yes No How often? __________

Marijuana? Yes No How often? __________

Recreational drugs? Yes No How often? __________

DENTAL HISTORY

Have you had any adverse effects from dental treatment? Yes No If Yes, please explain?______________________

Do you wish to talk to the doctor privately about anything? Yes No

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

____ ______________________________

Signature of patient, parent, guardian Date

____ ______________________________

Printed name of patient, parent, guardian/Relationship Doctor's Signature

HEALTH HISTORY UPDATE

Date	Comments	Doctor's Signature
__________	______________________________	______________________________
__________	______________________________	______________________________