

Patient Information

Name

First Name Last Name

Nickname

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Home Phone

Please enter a valid phone number.

Email

example@example.com

Work Phone

Please enter a valid phone number.

Cell/ Other Phone

Please enter a valid phone number.

Birth Date



Month Day Year

Gender

Male

Female

SSN# (U.S.only)

Referred By:

If patient is a minor, parent's /guardian's name

First Name

Last Name

Responsible Party Information

Name

First Name

Last Name

Residence

Street Address

Street Address Line 2

Mailing Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

How long at this address?

Home Phone

Please enter a valid phone number.

Work Phone

Please enter a valid phone number.

Cell/Other Phone

Please enter a valid phone number.

If patient is under 18, please complete this section.

SSN# (U.S. only)

Birth date



Day Year

Relationship to Patient

Employer

Occupation

Number of Years Employed

Spouse's Name

Relationship to Patient

Employer

Occupation

SSN# (U.S. only)

Birth date



Month Day Year

Home Phone

Please enter a valid phone number.

Work Phone

Please enter a valid phone number.

Cell/Other Phone

Please enter a valid phone number.

Email

example@example.com

Dental Insurance Information

Primary Insurance Information

Insured's Name

First Name Last Name

Insured Person's Date of Birth



Month Day Year

Insured's SSN# (U.S. only)

Insurance Company

Group Number

Local Number

Insurance Company Address

Phone Number

Please enter a valid phone number.

Do you have dual coverage?

Secondary Insurance Information

Insured's Name

First Name Last Name

Insured Person's Date of Birth



Month Day Year

Insured's SSN# (U.S. only)

Insurance Company

Group Number

Local Number

Insurance Company Address

Phone Number

Please enter a valid phone number.

Emergency Information

Name of the nearest relative not living with you

First Name Last Name

Phone Number

Please enter a valid phone number.

Complete Address

Street Address

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician Name

First Name Last Name

Date of Last Visit



Month Day Year

Phone Number

Please enter a valid phone number.

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Dental History

Dentist Name

First Name Last Name

Last date of visit:



Month Day Year

What concern you most about your teeth?

Please check any of the following which apply to you and add any relevant comment:

Yes No Please add any relevant
Comment?

Are you presently in any dental pain?

Have you ever experienced any unfavorable reaction to dentist?

Have you ever lost or chipped any teeth?

Have there been any injuries to face, mouth or teeth?

Is any part of your mouth sensitive to temperature or pressure?

Do your gums bleed when you brush?

Do you have any type of thumb or tongue habit?

Are you a mouth breather?

Please check any of the following which apply to you and add any relevant comment:

Yes No Please add any relevant
Comment?

Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Are you aware of your jaws clicking or popping?

Are you aware of clenching your your teeth during the day?

Have you ever been told that you grind your teeth?

Do you have 'tension' headaches?

Have you ever experienced chronic ringing in your ears?

Do you have any extra or missing teeth?

Are you happy with the way your smile looks? If not what would you change?

Health History

Patient Name

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. Thankyou for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit?

Are you in good health?

Yes

No

Have there been any changes in your general health in the past year?

Yes

No

Are you under the care of a physician?

Date of last visit



Month Day Year

If so, for what are you being treated?

Have you had any illness, operation or been hospitalized in the past five years?

Yes

No

If so, describe?

Do you have unhealed/ recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?

Yes

No

If so, describe?

Do you have a prosthetic joint/ implant?

Yes

No

If so, describe where?

Have you had a heart valve replacement or vascular graft?

Yes

No

Have you ever had general anesthesia?

Yes

No

Have you, or a family member, had any unusual or serious reactions to general anesthesia?

Yes

No

Has a physician or previous dentist recommended that you take antibiotics pripr to your dental treatment?

Yes

No

Have you ever had, or do you currently have:

Yes

No

Rheumatic fever

Damaged heart valves/ mitral valve

Heart murmur?

High blood pressure?

Low blood pressure?

Chest pain/ angina?

Heart attack(s)?

Irregular heart beat?

Cardiac pacemaker?

Heart surgery?

Pneumonia, bronchitis, chronic cough?

Asthma?

Hay fever/ sinus problems?

Snoring?

Sleep apnea/CPAP?

Difficult breathing/ other lung trouble?

Tuberculosis?

Emphysema?

Blood transfusion?
Blood disorder such as anemia?
Bruise easily?
Bleeding tendency/ abnormal bleed?
Hepatitis, jaundice, or liver disease?
Infectious mononucleosis?
Gallbladder trouble?
Fainting spells?
Convulsions / epilepsy?
Stroke?

Have you ever had, or do you currently have:

Yes No

Thyroid trouble?
Diabetes?
Low blood sugar?
kidney trouble?
High cholesterol?
Are you on dialysis?
Swollen ankles/ arthritis / joint disease?
Osteonclerosis?
Stomach ulcer/ acid reflux?
COVID-19?
Contagious disease?
Sexually transmitted disease?
Problems with immune system? Possibly from medication/ surgery,etc.
Autoimmune disease?
Delay in healing?
A tumor or growth?
Cancer/ radiation therapy/ chemotherapy?

Chronic fatigue / night sweats?

Are you on a diet?

Is there a history of alcohol abuse and/ or treatment for alcohol abuse?

A history of marijuana or illegal drug use?

Contact lenses?

Eye disease/ glaucoma?

Mental health problems/ anxiety/ depression?

A removable dental appliance?

Pain or clicking of jaws when eating?

Do you smoke or vape?

Yes

No

If so, how much a day

Do you use chewing tobacco?

Yes

No

Alcohol intake?

Yes

No

If so, drinks per

Day

Week

Women Only

Is there a possibility of pregnancy?

Expected delivery date?

Are you nursing?

Yes

No

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.

Are you now taking:

Yes No Notes

Any kind of medication, drug, pills?

Blood thinners (Coumandin, Placix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Xarelto, Eliquis, Fish oil)?

Have you ever taken diet pills?

Any natural product, herbal supplement or homeopathic remedy?

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, Xgevsu, or Evista in the past 12 years?

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

If you are under the care of a physician for pain management, or recovering from drug addiction

please select the medication you are currently taking:

Methadone

Suboxone

Oxycodone

Fentanyl

Treating Doctor:

Please list any medications you are currently taking:

Medication

Dosage

Frequency

Is there any condition concerning you health that the doctor should be told about ?

Yes

No

If yes, describe

Do you wish to speak to the Dr. privately about anything?

Are you Allergic to, Or had a Reaction to:

Yes No Notes

Local anesthetic (numbing meds.)?

Penicillin?

Other antibiotics?

Sulfa drugs?

Sodium pentothal/ Valium/ Other tranquilizers?

Aspirin?

Amoxicillin?

Codeine or other narcotics?

Latex?

Soy?

Eggs/ yolk?

Sulfites?

Do you have any known allergies?

Please list any allergies other than drug allergies:

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

Is there a family history of:

Cancer

Diabetes

Heart disease

Anesthesia problems