Implant & Oral Surgery Center
at Maple Lawn

HEALTH HISTORY

Patient's Name_____ Date_____

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: .....Y N

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6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
   - B. Congenital Heart Disease? .....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
   - H. Kidney Disease? .....Y N
   - I. Diabetes?.....Y N
   - J. Thyroid Disease (Goiter)?.....Y N
   - K. Arthritis?.....Y N
   - L. Stomach Ulcers or Colitis?.....Y N
   - M. Glaucoma?.....Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N
   - O. Radiation (X-ray) treatment for Cancer? .....Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)? .....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.Y N
   - D. High Blood Pressure medications? .....Y N
   - E. Steroids (Cortisone, etc.)? .....Y N
   - F. Tranquilizers? .....Y N
   - G. Insulin or Oral Anti-Diabetic drugs? .....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug?.....Y N
   - I. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

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9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? .....Y N
   - B. Penicillin or other antibiotics? .....Y N
   - C. Sedatives, Barbiturates?.....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers? .....Y N
   - F. Latex or Rubber Products? .....Y N
   - G. Other allergies or reactions? Please, list.....Y N

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10. Do you smoke or chew Tobacco?.....Y N How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Have you had any serious problems associated with any previous dental treatment?.....Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? .....Y N
15. Do you wish to talk to the doctor privately about anything? .....Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing?.....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

NEW PATIENTS' INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (*First, M.I., Last):*

Date of Birth: Age: Sex: Male / Female Marital Status: S M W D

Address: (Street) (City) (State) (ZIP)

Phone #: Social Security #: Driver's License #:

Work #: Employer:

Employer's Address:

Referring Physician: If Student, School Name: Full / Part Time

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: Relationship to Patient:

Address:

Phone #: Social Security #: Driver's License #:

Employer: Work #:

Employer's Address:

Friend or Relative Not Living with You:

INSURANCE INFORMATION

Insurance Co.:		Phone #:
Insurance Address:		
Group #:	Certificate or ID #:	
Insured's Name:	Relationship to Patient:	Self / Spouse / Dependent
Insured's Employer:		Phone #:
Employer's Address:		
Insured's Social Security #:	Date of Birth:	Sex: Male / Female

I hereby assign, transfer, and set over to the Implant & Oral Surgery Center at Maple Lawn all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date