

# ***CAPITOL ORAL, FACIAL & IMPLANT SURGERY***

## ***WELCOME TO OUR PRACTICE***

### **Patient:**

(Mr \_\_\_ Mrs \_\_\_ Dr \_\_\_ Ms \_\_\_) First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referred By \_\_\_\_\_

Who will be responsible for account? Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐

### **Emergency Contact:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Telephone (\_\_\_\_) \_\_\_\_\_

### **Home Address:**

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

### **Referral:**

Name of Referring Dentist or Provider: \_\_\_\_\_ Address: \_\_\_\_\_

Name of General Dentist: \_\_\_\_\_ Address: \_\_\_\_\_

### **Employment History or School:**

Employer or School Name \_\_\_\_\_

Business Address \_\_\_\_\_

Business Telephone (\_\_\_\_) \_\_\_\_\_ Plan Name \_\_\_\_\_

### **Primary Dental Insurance Company**

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Party \_\_\_\_\_ Relation \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

### **Primary Medical Insurance Company**

Ins. Co. Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured Party \_\_\_\_\_ Relation \_\_\_\_\_

Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

# ***CAPITOL ORAL, FACIAL & IMPLANT SURGERY***

## ***WELCOME TO OUR PRACTICE***

### **To our patients:**

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a 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. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

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

Is there any condition concerning your health or your family's anesthetic history that the doctor should be told? \_\_\_\_\_

Do you have a prosthetic joint or valve? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you smoke or chew tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you consume alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_

**Medications:** Please list all medications, drugs, pills, or herbs you are currently taking:

\_\_\_\_\_

**Allergies:** Please list all allergies you have including **Penicillin, Aspirin and Eggs or Egg products:**

\_\_\_\_\_

### **Women:**

Is there a possibility that you may be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Have you had or do you currently have...</b>	<b>Yes</b>	<b>No</b>	<b>Have you had or do you currently have...</b>	<b>Yes</b>	<b>No</b>
Prosthetic Heart Valve			Stroke		
Congenital Heart Disease			Thyroid Trouble		
Previous Endocarditis			Diabetes		
High Blood Pressure			Low Blood Sugar		
Cardiac Transplant			Kidney Trouble		
Chest Pain, Angina			Are you on Dialysis		
Heart Attack			Swollen ankles, Arthritis or Joint Disease		
Irregular Heart Beat			Stomach Ulcer		
Cardiac Pacemaker			Contagious Disease		
Heart Surgery			Sexually Transmitted Disease		
Bronchitis, Chronic Cough			Problems of the Immune System		
Asthma			A tumor or Growth		
Hayfever / Sinus Problems			Mental Health Problems		
Tuberculosis			Are you wearing a removable dental appliance		
Emphysema			Are you on a diet		
Difficulty Breathing			Are you taking Bisphosphonates (Fosamax, etc.)		
Blood Transfusion			Contact Lenses		
Blood Disorder such as Anemia			Eye Disease / Glaucoma		
Bruise Easily			Radiation Treatment / Chemotherapy		
Abnormal Bleeding Tendency			Pain and Clicking of the Jaws		
Jaundice, Hepatitis or Liver Disease			Malignant Hyperthermia		
Infectious Mononucleosis			Convulsions / Epilepsy		

I certify that I have read and understand the questions above. I will not hold my surgeon or any members of his / her staff responsible for any errors or omissions that I have made in the completion of this form.

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_