HEALTH HISTORY

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 medication 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.

Are you in good health? _____ Height _____ Weight _____
Have there been any changes in your general health in the past year? _____
Are you under the care of a physician? _____ Date of last visit: _____
If so, for what are you being treated? _____
Have you had any illness, operation or been hospitalized in the past five years? _____
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? _____
If so, describe where:_____
Do you have a prosthetic joint/implant: _____ If so, describe where: _____
Have you had a heart valve replacement or vascular graft? _____
When did you last eat or drink anything? _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE

	YES	NO		YES	NO		YES	NO
Rheumatic fever?			Blood transfusion?			Contagious diseases?		
Damaged heart valves / Mitral valve prolapse?			Blood disorder (such as anemia)?			Sexually transmitted diseases?		
Heart murmur?			Bruise easily?			Delay in healing?		
High blood pressure?			Bleeding tendency (abnormal bleed)?			Problems with the Immune system?		
Low blood pressure?			Jaundice, hepatitis or Liver disease?			X-ray treatment / Chemotherapy?		
Chest pain, angina?			Infectious mononucleosis?			A tumor or growth?		
Heart attack(s)?			Gallbladder trouble?			Chronic fatigue/night sweats?		
Irregular heart beat?			Fainting spells?			Are you on a diet?		
Cardiac pacemaker?			Convulsions, epilepsy?			A history of drug abuse?		
Heart surgery?			Stroke?			A history of alcohol abuse?		
Bronchitis, chronic cough?			Thyroid trouble?			Contact lenses?		
Asthma?			Diabetes?			Eye disease/glaucoma?		
Hay fever / sinus problems?			Low blood sugar?			Mental health problems?		
Tuberculosis?			Kidney trouble?			Removable dental appliance?		
Emphysema?			Are you on dialysis?			Malignant hyperthermia?		
Difficult breathing / Other lung trouble?			Swollen ankles, arthritis Or joint disease			Pain and clicking of jaws When eating?		
Do you smoke?			Stomach ulcer?					

WOMEN ONLY:
Is there a possibility of pregnancy? ☐ yes ☐ no Estimated delivery date? __/__/__
Are you nursing? ☐ yes ☐ no Are you taking birth control pills? ☐ yes ☐ no

Please list any and all medications you are now or have been recently taking: _____
_____

Allergic reaction to drugs/food? _____

I certify that I have read and I understand the questions above . I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ Reviewed by:_____Date: _____
(Parent or Guardian if minor)

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys' fees, and court costs.

Signature of patient: (Parent or Guardian if minor) _____Date: _____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: (Parent or Guardian if minor) _____Date: _____