Green
ORAL SURGERY

Please Print All Information

Patient Information and Medical History

Name | Home Phone | Cell Phone | Work Phone

Mailing Address Street | Apartment # or Floor | City/Town | State | Zip

Date of Birth | Age/ Sex | Social Security # | Driver's License # | Marital Status

❑ **Student**/School Name | School Location | School Address | City/Town | State | Zip

❑ **Employed**/ Employer's Name | Employer's Address | City/Town | State | Zip

Family Members (who have been seen here)

Referred by: ❑ **Dentist** (Name) ❑ **Orthodontist** (Name) ❑ **Physician** (Name)

Responsible Party Information (if different from Patient Informaton above and/or Parent or Legal Guardian with Patient under 18 at time of Surgery)

Name | Home Phone | Relationship (self/child/spouse)

Mailing Address Street | Apartment #/Floor | City/Town | State | Zip

Date of Birth | Social Security Number

❑ **Employed**/Employer's Name | Employer's Address | City/Town | State | Zip

Primary Dental Insurance Company

Policy Holder:

Relation to patient:

Date of Birth: SS#

Home Phone:

Address:

Policy Holder's Employer:

Dental Insurance Company:

Insurance Mailing Address:

ID# Group #

Primary Medical Insurance Company

Policy Holder:

Relation to patient:

Date of Birth: SS#

Home Phone:

Address:

Policy Holder's Employer:

Medical Insurance Company:

Insurance Mailing Address:

ID# Group #

Secondary Dental Insurance Company

Policy Holder:

Relation to patient:

Date of Birth: SS#

Home Phone:

Address:

Policy Holder's Employer:

Secondary Dental Insurance Company:

Insurance Mailing Address:

ID# Group #

Secondary Medical Insurance Company

Policy Holder:

Relation to patient:

Date of Birth: SS#

Home Phone:

Address:

Policy Holder's Employer:

Secondary Medical Insurance Company:

Insurance Mailing Address:

ID# Group #

1. **Are you in good health?** Y N

2. **Have there been any changes in your general health in the past year?** Y N

   (If yes, please list) _____

3. **Date of last physical exam?** _____

4. **Are you under a physician's care for a particular problem?** Y N

   (If yes, what for) _____

5. **Have you had any serious illnesses, operations or hospitalization?** Y N

   (If yes, describe) _____

6. **Have you had any adverse effects from dental treatment?** Y N

7. **Do you smoke or chew tobacco?** Y N

   (How much daily) _____

8. **Do you use alcohol?** Y N

   (How much) _____

9. **Have you ever sought professional care for drug abuse, alcoholism or emotional disorders?** Y N

10. **Women**

    A. Are you pregnant or planning pregnancy? Y N

    B. Are you taking birth control pills? Y N

    C. Are you taking hormone replacements? Y N

11. **Do you wish to talk to the doctor privately about anything?** Y N

    (If yes, describe) _____

12. **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 trouble, heart angina, 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, Psychiatric Treatment, Dizzines, Nervous Disorder or Breakdown Y N

    F. 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 Y N

    K. Arthritis Y N

    L. Stomach Ulcers or Colitis Y N

    M. Glaucoma Y N

    N. Frequent or Recurring Mouth Sores Y N

    O. Implants placed *anywhere* in your body (heart valve, hip, knee), mouth Y N

    P. Radiation (X-Ray) treatment for cancer Y N

    Q. Clicking or popping of jaw joint, pain near ear difficulty opening mouth, grinding or clenching of teeth Y N

    R. Sinus or Nasal Problems Y N

    S. Any disease(s), drug(s) or transplant operation(s) that have depressed your immune system Y N

    T. Recurrent infections of any kind Y N

    U. Problems with your immune system Y N

Physician's Notes:

13. Are you taking any of the following?

A. Medication for Acid Reflux or Indigestion	Y	N
B. Thyroid Medications	Y	N
C. Antibiotics	Y	N
D. Anticoagulants	Y	N
E. High Blood Pressure	Y	N
F. Steroids (Cortizone, etc)	Y	N
G. Tranquilizers (Valium, etc)	Y	N
H. Insulin, Diabinese, or similar drug	Y	N
I. Digitalis, Inderal, Nitroglycerin, Calcium Channel Blockers, or other heart medicine	Y	N
J. Aspirin, Ibuprofen (Motrin, Naprosyn, etc.)	Y	N
K. Marijuana or other "street drugs"	Y	N
L. Antihistamines or decongestants	Y	N
M. Medication for Osteoporosis	Y	N
N. Are you taking any other regular medications, pills, or drugs?	Y	N

(If yes, please list) _____

14. Are you allergic or have had a bad reaction to?

A. Local anesthetic (novocaine, etc,)	Y	N
B. Penicillin, amoxicillin, cephalosporins or other antibiotics	Y	N
C. Barbituates, sedatives, etc	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	Y	N

(If yes, please list) _____

15. Do you have any other disease, condition or problem - not listed above that you think the doctor should know about? Y N

Accident Information

Patient Name: _____

Account #: _____

Date of Accident: _____

Accident Related to: ❑ Work ❑ Auto

❑ Other _____

Insurance Company : Claim #

Attorney/Adjustor Name: _____

Telephone Number: _____

Brief Description of Accident: _____

Payments, Fees & Insurance

I authorize my insurance company to pay benefits to Green River Oral Surgery LLC and that any balance after my Insurance has paid is *my responsibility*.

Signature of Policy Holder: Date

I understand that I am responsible for service rendered to myself or my dependent at the time of service.

Signature of Responsible Party: Date

Medical History Accuracy

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 health history with my doctor.

Signature of person completing health history Dr.'s initials

Medical Update: I have read my medical history dated ___/___/___ and confirm that it adequately states past and present conditions.

Date Exceptions or changes **Parent's signature** Dr.'s initials