Medical Alert for Office Use

WOODBRIDGE ORAL AND MAXILLOFACIAL SURGERY

4585 Daisy Reid Ave. Suite 105, Woodbridge, VA 22192
TEL: (703) 670-6886 FAX: (703) 670-3108

Thank you for visiting Woodbridge Oral And Maxillofacial Surgery. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION

DATE:

Name ______________________________
LAST FIRST MIDDLE INITIAL NICKNAME

Address ______________________________
STREET

____
CITY STATE ZIP

Employer ______________ E-mail Address ______________

Drivers License______________ Occupation______________

Birth Date ______________ Height ______________ Weight ______________

Phone: Home (   ) ______________ **Social Security #**______________

Work (   ) ______________ May we contact you at work? ❑ Yes ❑ No

Mobile (   ) ______________ ❑ Male ❑ Female

Emergency: Name ______________ Phone (   ) ______________ Relationship: ______________

Please Circle: Single Married Divorce Widow Child

INSURANCE

Primary Dental Carrier

Subscriber Name ______________ SSN / ID# ______________ DOB ______________

Employer ______________ Insurance Co. ______________

Insurance Co. Phone # ______________ Group # ______________

Relation to patient ______________

Secondary Dental Carrier

Subscriber Name ______________ SSN / ID# ______________ DOB ______________

Employer ______________ Insurance Co. ______________

Insurance Co. Phone # ______________ Group # ______________

Relation to patient ______________

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature______________________________ **Date** ______________

IF PATIENT IS UNDER 18

Responsible Party ______________ Relation to Patient ______________

Address ______________________________
STREET

____
CITY STATE ZIP

Telephone (   ) ______________

ORAL SURGERY HEALTH QUESTIONNAIRE

PATIENT NAME: ____ **BIRTH DATE:** ______________

AGE:_________ **SEX:** ___________ **HEIGHT:** ____________ **WEIGHT:** ___________

PLEASE ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED.

ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL.

1. Have you had any food today?.................................... ☐Yes ☐No
2. Are you in good health?... ☐Yes ☐No
3. Your last physical examination was on _________
4. Are you under the care of a physician?........................ ☐Yes ☐No
   If so, what is the condition that is being treated?
   ____
5. Name and telephone number of the physician
   ____
6. Have you had any serious illness, operation, or been hospitalized? ☐Yes ☐No
   If yes, what was the problem and when?
   ____
7. Do you drink alcoholic beverages?............................ ☐Yes ☐No
8. Have you had an abnormal bleeding associated with previous extractions, surgery, or trauma? ☐Yes ☐No
   A. Do you bruise easily?
   B. Have you ever required a blood transfusion?
   If yes, explain circumstances:________________
   ____
9. Do you have any bleeding disorder such as anemia?... ☐Yes ☐No
10. Are you taking any drug or medication? .... ☐Yes ☐No
    If yes, what medication? ____________________
    ____
11. Are you taking any of the following?
    A. Antibiotics or sulfa drugs.. ☐Yes ☐No
    B. Anticoagulants (blood thinner).. ☐Yes ☐No
    C. Medicine for high blood pressure............................. ☐Yes ☐No
    D. Cortisone (steroids) .... ☐Yes ☐No
    E. Tranquilizers .... ☐Yes ☐No
    F. Aspirin.. ☐Yes ☐No
    G. Insulin, Tolbutamide.. ☐Yes ☐No
    H. Digitalis or drugs for heart problems......................... ☐Yes ☐No
    I. Nitroglycerin .... ☐Yes ☐No
    J. Are you taking or have you ever taken.................... ☐Yes ☐No
    Bisphosphonates (Foxmax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos, or Zometa) for osteoporosis, or chemotherapy for multiple myeloma, etc.
    K. Fen-phen (now or in the past) or related drugs such as Lonimin, Adipex, Phentramine, Fastin, Pondimin (fenfluramine), and Redux (dexfenfluramine) ☐Yes ☐No
    L. Other: ______________________________
12. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips? ☐Yes ☐No
13. Are you pregnant?.. ☐Yes ☐No
14. Are you allergic or have you reacted adversely to:
    A. Iodine .... ☐Yes ☐No
    B. Local Anesthetic .... ☐Yes ☐No
    C. Penicillin or other antibiotics .... ☐Yes ☐No
    D. Sulfa Drugs .... ☐Yes ☐No
    E. Barbiturates, sedatives, sleeping pill .... ☐Yes ☐No
    F. Aspirin .... ☐Yes ☐No
    G. Soybean or egg .... ☐Yes ☐No
    H. Latex .... ☐Yes ☐No
    I. Other: _______________________ .... ☐Yes ☐No
15. Have you had any adverse reaction associated with previous medical treatment? ☐Yes ☐No
    If so, please explain: ____________________
    ____
16. Have you had any adverse reaction associated with previous medical treatment? ☐Yes ☐No
    If so, please explain:_____________________
    ____
17. Have you had any of the following illnesses? Please answer YES or NO to all items below.
    - AIDS .... ☐Yes ☐No
    - Allergies.. ☐Yes ☐No
    - Anemia.. ☐Yes ☐No
    - Angina .... ☐Yes ☐No
    - Arthritis .... ☐Yes ☐No
    - Artificial Joint Replacement .... ☐Yes ☐No
    - Asthma .... ☐Yes ☐No
    - Cancer .... ☐Yes ☐No
    - Diabetes .... ☐Yes ☐No
    - Emphysema .... ☐Yes ☐No
    - Epilepsy .... ☐Yes ☐No
    - Fainting... ☐Yes ☐No
    - Glaucoma .... ☐Yes ☐No
    - Heart Attack .... ☐Yes ☐No
    - Hepatitis .... ☐Yes ☐No
    - High Blood Pressure .... ☐Yes ☐No
    - HIV Positive .... ☐Yes ☐No
    - Kidney Disease .... ☐Yes ☐No
    - Liver Problem .... ☐Yes ☐No
    - Low Blood Pressure .... ☐Yes ☐No
    - Lung Disease .... ☐Yes ☐No
    - Rheumatic Fever .... ☐Yes ☐No
    - Stroke .... ☐Yes ☐No
    - Thyroid .... ☐Yes ☐No
    - Tuberculosis .... ☐Yes ☐No
    - Venereal Disease .... ☐Yes ☐No
    - Other: ____________________ .... ☐Yes ☐No

I have filled out this health questionnaire completely.

I have advised you of all medical problems of which I am aware.

Patient Signature: ____________________ Date: __________

I have reviewed the health history form above.

Doctor Signature: _______________________ Date:__________