# Ithaca Oral Surgery and Implant Center

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- - Practice Limited to Oral & Maxillofacial Surgery - -
Not an NY Article 28

## 1. Patient Information Record  Pt. Chart # _____

The following information is needed for our records. Please PRINT answers to all questions and sign where indicated on the back of this sheet.

Patient Name: _____
**First** **Middle Initial** **Last**

Date of Birth: _____ Age: _____ [ ] Male [ ] Female Marital Status _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone: _____ Social Security #: _____
Work Phone: _____ email address_____

## 2. Insurance Information

Policy Holder – Patient/Spouse/Parent (circle one)
Employed By: _____ Occupation _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Length of Time Employed: _____

PRIMARY Dental Insurance: _____ ID/SS #: _____
Policy Holder: _____ DOB: _____ Group #: _____

SECONDARY Dental: _____ ID/SS #: _____
Policy Holder: _____ DOB: _____ Group #: _____

PRIMARY Medical Insurance: _____ ID/SS #: _____
Policy Holder: _____ DOB: _____ Group #: _____

SECONDARY Medical: _____ ID/SS #: _____
Policy Holder: _____ DOB: _____ Group #: _____

Name of Parent or Guardian if Patient is a Minor: _____

Patient Referred By: _____
Name of General Dentist: _____
Name of Regular Physician: _____ Phone: _____
Pharmacy of Choice_____

## 3. Medical History

1. Are you now or have you been under the care of a physician during the past 5 years? [ ] Yes [ ] No
If YES, please explain: _____
_____
_____

2. Do you take any medications regularly? [ ] YES [ ] NO Are you taking any now? [ ] YES [ ] NO
If YES, please list <u>Medications:</u> <u>Dosage:</u>
_____ _____
_____ _____
_____ _____
_____ _____

**<u>*** Have you ever had any surgeries or hospitalizations?</u>** [ ] YES [ ] NO

3. Have you ever had breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorder? [ ] YES [ ] NO

4. Do you smoke? [ ] YES [ ] NO If YES, how much? _____

**TELL US ABOUT ANY SURGERIES OR HOSPITALIZATIONS**

***Circle any of the following which you have or had in the past:***

| | | |
|---|---|---|
| Heart Failure | Emphysema | Hepatitis A (infectious) |
| Heart disease or attack | Cough | Hepatitis B (serum) |
| Angina Pectoris | Tuberculosis | Liver Disease |
| High Blood Pressure | Asthma | Jaundice |
| Heart Murmur | Hay Fever | Blood Transfusion |
| Rheumatic Fever | Sinus Trouble | Drug Addiction |
| Congenital Heart Lesions | Allergies or Hives | Hemophilia |
| Scarlet Fever | Diabetes | Venereal Disease |
| Artificial Heart Valve | Thyroid Disease | Genital Herpes |
| Heart Pacemaker | x-ray or Cobalt x-ray | Epilepsy or Seizures |
| Heart Surgery | Chemotherapy | Fainting or Dizzy Spells |
| Artificial Joint | Arthritis | Psychiatric Treatment |
| Anemia | Rheumatism | Sickle Cell Disease |
| Stroke | Cortisone Medication | Bruise Easily |
| Kidney Trouble | Glaucoma | Latex Allergy |
| Ulcers | Pain in Jaw Joints | HIV/AIDS |

5. Are you allergic to ANY medications? [ ] YES [ ] NO

If YES, what? _____

6. Have you ever had undesirable effects from taking these drugs? If YES, please circle.

| | | | |
|---|---|---|---|
| General Anesthetics | Pain Killers | Antibiotics | Sleeping Pills |
| Local Anesthetics | Cortizone | Laxatives | Sedatives |
| Vitamins | Tranquilizers | Stimulants | Mouth Wash |

7. Do you have popping or clicking in your jaw? [ ] YES [ ] NO
8. Have you had TMJ problems in the past? [ ] YES [ ] NO
9. Do you bleed easily or for long periods? [ ] YES [ ] NO
10. Do you now have a cold, cough or sinus trouble? [ ] YES [ ] NO
11. Do you wear contact lenses? [ ] YES [ ] NO
12. If female…are you pregnant? [ ] YES [ ] NO
13. When you walk up stairs or exercise, do you ever experience chest pain or shortness of breath or have to stop simply because you are very tired? [ ] YES [ ] NO
14. Do your ankles swell during the day? [ ] YES [ ] NO
15. Do you use more than 2 pillows to sleep? [ ] YES [ ] NO
16. Do you have any disease, problem, or condition not listed above? [ ] YES [ ] NO
17. ARE YOU ALLERGIC TO EGGS OR SOY [ ] YES [ ] NO

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my medical history (including changes in medicine) or health, I will inform the doctor of dentistry at my next appointment.*

Signed_____ Date _____ Updated:_____ Signed _____

Updated _____ Signed_____

Updated _____ Signed _____

BP _____ Pulse _____ PulseOx RA_____

**CHIEF COMPLAINT** _____

AAOMS VIDEO VIEWED [ ] YES [ ] NO Date _____

History Reviewed By: _____

NOTES: