OC ORAL SURGERY

JUNIL AHN, DDS, MD
Diplomate, American Board of Oral and Maxillofacial Surgery

PATIENT INFORMATION RECORD

Date: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Home #: _____ Cell #: _____ Work #: _____

Company/Employer Name: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ ZIP: _____

INSURANCE INFORMATION:

Who will be financially responsible for this account? _____

Primary Dental Insurance Name: _____

Dental Insurance Primary Subscriber Name: _____

Dental Insurance Primary Subscriber ID: _____ Social Security #: _____

Dental Insurance Primary Subscriber Date of Birth: _____ Group #: _____

Secondary Dental Insurance: ..... ☐ Yes ☐ No

Secondary Dental Insurance Name: _____

Dental Insurance Primary Subscriber Name: _____

Dental Insurance Primary Subscriber ID: _____ Social Security #: _____

Dental Insurance Primary Subscriber Date of Birth: _____ Group #: _____

We are not in-network providers with any medical carriers; however, some dental plans require denial from a medical plan before processing dental claims...

Medical Insurance Name: _____

Medical Insurance Primary Subscriber Name: _____

Medical Insurance Primary Subscriber ID: _____ Date of Birth: _____

Have you or any member of your family been a patient of our office? ..... ☐ Yes ☐ No

If yes, name of prior patient _____

Whom do we thank for referring you to our office? _____

HEALTH HISTORY

Patient Name: _____

Age: _____ Height: _____ Weight: _____

ALLERGIES: Are you allergic to or have you had adverse reactions to:

- ☐ Local Anesthesia (Novocain, Lidocaine, etc)
- ☐ Penicillin, Keflex, Clindamycin
- ☐ Other Antibiotics
- ☐ Aspirin, Ibuprofen, Motrin, Aleve, Advil, NSAID
- ☐ Codeine, Vicodin, Darvocet, Percocet
- ☐ Other Prescribed Pain Medication
- ☐ Latex, Tape, or Any Other Materials
- ☐ Metals of Any Type
- ☐ Food Products Including Egg or Soy Products

Please list all known allergies : _____

_____

MEDICATIONS: Do you take any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants (Coumadin, Warfarin)
- ☐ Aspirin, Plavix, Motrin, Aleve, Ibuprofen, NSAID
- ☐ Blood Pressure Medications
- ☐ Steroids (Prednisone, Cortisone)
- ☐ Heart or Blood Pressure Medicines

Please list any and all prescribed medications, over-the-counter medications, herbal medications, dietary supplements, or diet medications: _____

_____

Answer all questions by checking Yes or No.

- Are you in good health? ☐ Yes ☐ No
- Have there been any changes in your health in the past year? ☐ Yes ☐ No
- Are you under a physician's care for a particular problem? ☐ Yes ☐ No
- Have you ever had any serious illnesses, emergency room visits, or hospitalizations? ☐ Yes ☐ No
  If so, please describe: _____
- Have you ever had surgery before? ☐ Yes ☐ No
  If so, please describe: _____
- Did you have any complications with the surgery or with the anesthesia used, including nausea, vomiting, or difficulties with anesthesia? ☐ Yes ☐ No
  If so, please describe: _____
- Do you or ***have you ever taken*** bisphosphonate medications for osteoporosis, cancer, or multiple myeloma (such as Fosamax, Actonel, Boniva, Reclast, Aredia, or Zometa)? ☐ Yes ☐ No
  If so, for how long (months or years) _____

DO YOU HAVE OR HAVE YOU EVER HAD: Check all that apply.

- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Congenital Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Seizures
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Bleeding Disorders
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Easy Bruising
- ☐ Blood Transfusions
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Dialysis
- ☐ Kidney Failure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Acid Reflux
- ☐ Arthritis/Osteoarthritis or Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Heart Valve
- ☐ Hip or Knee Replacement
- ☐ Cancer
- ☐ Radiation Therapy or Chemotherapy
- ☐ Jaw pain/TMJ problems
- ☐ Clenching/Grinding
- ☐ Sleep Apnea
- ☐ Sinus/Nasal problems
- ☐ Immunocompromise
- ☐ Organ Transplant
- ☐ Chronic Pain/Fibromyalgia or Neuropathic Pain
- ☐ Autoimmune Disease (Lupus, Connective Tissue Disease, Others)
- ☐ Alcohol/Chemical Dependency
- ☐ Smoke/Chew Tobacco (_____/Day - Years: _____)
- ☐ Undiagnosed Health Problem (List: _____ _____)

- Any psychiatric diagnosis or other emotional problems? ☐ Yes ☐ No
- Any difficulties or serious problems with previous dental treatments? ☐ Yes ☐ No
- Any family members that have difficulty with IV or general anesthesia? ☐ Yes ☐ No
- Any other concerns or health problems that may affect treatment in our office? ☐ Yes ☐ No
- Have you had anything to eat or drink within 6 hours? ☐ Yes ☐ No
- Who is driving you home today? Name: _____ Ph#: _____

FOR WOMEN ONLY

- Are you pregnant or is there any chance you may be pregnant? ☐ Yes ☐ No
- Are you nursing? ☐ Yes ☐ No
- Do you take any oral contraceptives? ☐ Yes ☐ No

PATIENT INFORMATION RECORD (Cont.)

Your regular dentist: _____ Phone #: _____

Your orthodontist: _____ Phone #: _____

Your physician: _____ Phone #: _____

Are you under the care of any specialist? ☐ Yes ☐ No

If yes, please specify:

☐ Cardiologist ☐ Endocrinologist ☐ Oncologist ☐ Other:

☐ Neurologist ☐ Pulmonologist ☐ Orthopedic _____

Specialist's Name: _____ Phone #: _____

Prescriptions are sent electronically. Please provide your pharmacy of choice where we can send prescriptions to:

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____ City: _____ State: _____ ZIP: _____

The following people are authorized to speak on behalf of my account and/or treatment plan and have my full permission to have information about my care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____