



# OC ORAL SURGERY

JUNIL AHN DDS MD  
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## PATIENT INFORMATION RECORD

Date: \_\_\_\_\_

### PATIENT INFORMATION:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph#: \_\_\_\_\_

Email: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Company/Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### SPOUSE:

Spouse's Occupation: \_\_\_\_\_ Spouse Ph #: \_\_\_\_\_

Spouse's Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Who will be financially responsible for this account? \_\_\_\_\_

### INSURANCE INFORMATION:

**Primary Dental Insurance:** \_\_\_\_\_

Dental Insurance Primary Subscriber Name: \_\_\_\_\_

Dental Insurance Primary Subscriber ID/Social Security Number: \_\_\_\_\_

Dental Insurance Primary Subscriber Date of Birth: \_\_\_\_\_ Group #: \_\_\_\_\_

**Primary Medical Insurance:** \_\_\_\_\_

Medical Insurance Primary Subscriber name: \_\_\_\_\_

Medical Insurance Primary Subscriber ID: \_\_\_\_\_

Medical Insurance Primary Subscriber Date of Birth: \_\_\_\_\_ Group #: \_\_\_\_\_

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

If Yes, name of prior patient: \_\_\_\_\_

- Name of regular dentist: \_\_\_\_\_ Dentist's Ph #: \_\_\_\_\_

- Name of regular physician: \_\_\_\_\_ Physician's Ph #: \_\_\_\_\_

- Who can we thank for referring you to our office? \_\_\_\_\_



Date: \_\_\_\_\_

## HEALTH HISTORY

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

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

Please list all known allergies : \_\_\_\_\_

### MEDICATIONS: Do you take any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Antibiotics                                      | <input type="checkbox"/> Blood Pressure Medications        |
| <input type="checkbox"/> Anticoagulants (Coumadin, Warfarin)              | <input type="checkbox"/> Steroids (Prednisone, Cortisone)  |
| <input type="checkbox"/> Aspirin, Plavix, Motrin, Aleve, Ibuprofen, NSAID | <input type="checkbox"/> 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.

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

- 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

Signature: \_\_\_\_\_

Dr.'s Initials: \_\_\_\_\_