MIDDLETON ORAL SURGERY

PATIENT INFORMATION: DATE_____

Name: (Dr/Mr/Mrs/Ms) _____
(First) (M.I.) (Last)

Nickname/Preferred Name:_____

Address:_____

City:_____State:_____Zip:_____

Sex ☐ M ☐ F Social Security #_____ Birthdate _____/_____/_____ Age_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Occupation:_____Employer/School:_____

CONTACT INFORMATION: Home Phone:(_____)_____

Cell: (_____)_____Work: (_____)_____ EXT:_____

Dentist:_____ Referred By:_____

Reason for today's visit:_____

Primary Care Physician:_____ Phone #_____

Other Specialists:_____Phone#_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home Phone:_____ Cell/work Phone:_____

INSURANCE/PAYMENT INFORMATION

Primary Dental Insurance

_____
Policy Holders Name(if not self) SSN

_____
Relationship date of birth

Insurance Co._____

Policy/Group #_____

Secondary/Medical Insurance

_____
Policy Holders Name(if not self) SSN

_____
Relationship date of birth

Insurance Co._____

Policy/Group#_____

Assignment and Release: I assign directly to Dr. Scott A Middleton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.**

Signature_____ Date:_____

HEALTH HISTORY

Name_____ Age_____ Height_____ Weight_____

Do you have or have you had any of the following:

Autoimmune Disorders ☐ Yes ☐ No
If yes, please complete other side of form.
AIDS/HIV ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Artificial Heart Valves ☐ Yes ☐ No
Artificial Joints ☐ Yes ☐ No Premed_____
Asthma ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Bleeding Problems ☐ Yes ☐ No
Cancer/chemotherapy ☐ Yes ☐ No
Circulatory Problems ☐ Yes ☐ No
Congenital Heart disease ☐ Yes ☐ No
Cough/Chronic Bronchitis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No
Fainting or dizziness ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart disease/attack ☐ Yes ☐ No
Herpes ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Jaw Pain ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease/Hepatitis ☐ Yes ☐ No
If yes, type_____
OSTEOPOROSIS ☐ Yes ☐ No
If yes, please complete other side of form.
Radiation Treatment ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
TMJ Symptoms/TX ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Ulcers/colitis ☐ Yes ☐ No
Weight Loss, Unexplained ☐ Yes ☐ No

Do you take any blood thinners? ***If yes, please complete other side of form.***
Do you take or have been advised to take antibiotics prior to dental procedures? ☐ Yes ☐ No If yes, please specify_____
Have you or a family member ever had difficulty with sedation? ☐ Yes ☐ No
If Yes, how so?_____
Do you have any other diseases/conditions not listed above? ☐ Yes ☐ No If yes, please explain:_____
_____
Do you smoke or chew tobacco? ☐ Yes ☐ No If yes, how often?_____
Drink alcoholic beverages? ☐ Yes ☐ No If yes, how often?_____
Female Patients:
Are you, or could you be pregnant? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No
NOTE: Antibiotics may interfere with the effectiveness of oral contraceptives.
Are you nursing? ☐ Yes ☐ No
Are you under the care of an OB/GYN? ☐ Yes ☐ No
If yes, Please list_____

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

Are you allergic to or have you had an adverse Reaction to any of the following:

☐ Aspirin
☐ Sedatives/barbiturates
☐ Sulfa Drugs
☐ Iodine
☐ Local Anesthetic
☐ Penicillin
☐ Codeine
☐ Latex
☐ **Other** _____
_____

I CERTIFY THAT THE INFORMATION AND THE MEDICAL HISTORY I HAVE PROVIDED IS CORRECT:

X_____ _____
Patient's Signature OR Parent/Guardian Signature(if minor) Date

DOCTOR'S REVIEW: _____ ASSISTANT'S REVIEW: _____ DATE: _____

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If yes to **Autoimmune Disorder** – Do you or your family have any history of the following (please circle any and all that apply):

- Rheumatoid Arthritis
- Psoriatic Disease
- Sjogrens Disease
- Lupus
- Steroid Use
- Immunosuppressant use such as methotrexate

If yes to **Osteoporosis** – Please circle any and all that you are currently or have taken:

- Fosamax
- Actonel
- Boniva
- Prolia
- Reclast
- Zometa
- Aredia

If yes to taking **blood thinner** – Please circle any and all that you are currently or have taken:

- Aspirin
- Fish Oil
- Vitamin E
- Plavix
- Coumadin/Warfarin
- Xarelto
- Eliquis