Patient Information

Name _____ Date of Birth _____ Age_____
Social Security Number _____ Male_____ Female_____
Home Address _____City _____ State ____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____
Email Address _____

May we contact you via cell phone and/or email Yes_____ No_____

Employer _____ Occupation _____
Work Address _____City _____ State ____ Zip _____
Work Phone ( ) _____

Dentist_____ Orthodontist_____

Who may we contact in case of emergency _____/_____( )_____
Name Relationship Number
Person responsible for the account_____
If patient is a minor, under 18 years of age
Relationship _____ Home Phone ( )_____
SSN# _____Date of Birth _____ Work Phone ( )_____
Home Address _____City _____ ST_____ Zip _____

Who may we thank for referring you? _____phone ( )_____

Dental Insurance (Primary) Name of Insured _____ Date of Birth _____
Employer _____
Insurance Company Name _____
SSN# or ID #_____ Group # _____
Billing Address _____
City _____ State _____ Zip _____
Phone Number _____ Other_____

Dental Insurance (Secondary) Name of Insured _____Date of Birth _____
Employer _____
Insurance Company Name _____
SSN# or ID#_____ Group # _____
Billing Address _____
City _____State _____ Zip _____
Phone Number _____ Other _____

Medical Insurance (If Applicable)
Company Name _____
Insured _____ID # _____
Phone Number _____

*** Please check payment type Cash □ Check □ Visa / MC □ Discover □ Amex □

I acknowledge I have received a copy of this office's notice of Privacy practices.
Signature _____ Date _____
(Patient, or Guardian if patient is a minor)

Oral Surgery Health Questionnaire

Robert M. Svarney, Jr., D.D.S.

Specializing in Oral and Maxillofacial Surgery and Dental Implants
Diplomate, American Board of Oral and Maxillofacial Surgery

Patient Name: _____ Birth Date: _____
Last First Middle

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 food or drink today? YES NO
2. Are you 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. Do you smoke or use tobacco products? YES NO
9. Do you take vitamins and/or supplements? YES NO
10. Have you had abnormal bleeding associates with Previous extractions, surgery or trauma? YES NO
    A. Do you bruise easily? YES NO
    B. Have you ever required a blood transfusion? YES NO
       If yes, explain circumstances _____
11. Do you have any bleeding disorder such as anemia? YES NO
12. Are you taking any drug or medicine? YES NO
    If yes, what medication? _____
13. 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, Tolbutamid YES NO
    H. Digitalis or drugs for heart problems YES NO
    I. Nitroglycerin YES NO
    J. Are you taking or have you ever taken Bisphophonates (Fosamax, Actonel, Aredia, Boniva, Didronel, Skelid, Bonefos or Zometa) for osteoporosis, or chemotherapy for multiple myeloma, etc? YES NO
    K. Fen-phen (now or in the past) or related drug such as lonimin, Adipex, Phentramine, Fastin, Phondimin (fenfluramine), and Redux (dexfenfluramine) YES NO
    L. Other _____
14. Please answer the following questions with a yes or no.
    A. Do you grind your teeth at night? YES NO
    B. Do you have a history of jaw pain with opening and closing? YES NO
    C. Does your jaw pop or click when opening? YES NO
    D. Have you jaw been stuck open or closed? YES NO
15. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips? YES NO
16. Are you pregnant? YES NO
17. 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 pills YES NO
    F. Aspirin YES NO
    G. Soybean or egg YES NO
    H. Latex YES NO
    I. Other _____
18. Have you had any adverse reaction associated with previous dental treatment? YES NO
    If so, please explain _____
19. Have you had any adverse reaction associated with previous medical treatment? YES NO
    If so, please explain _____
20. Have you had any of the following illnesses?
    A. AIDS YES NO
    B. Allergies YES NO
    C. Anemia YES NO
    D. Angina YES NO
    E. Arthritis YES NO
    F. Artificial Joint Replacement YES NO
    G. Asthma YES NO
    H. Cancer YES NO
    I. Diabetes YES NO
    J. Emphysema YES NO
    K. Epilepsy YES NO
    L. Fainting YES NO
    M. Glaucoma YES NO
    N. Heart Attack YES NO
    O. Hepatitis YES NO
    P. High Blood Pressure YES NO
    Q. HIV Positive YES NO
    R. Kidney Disease YES NO
    S. Liver Problem YES NO
    T. Low Blood Pressure YES NO
    U. Lung Disease YES NO
    V. Rheumatic Fever YES NO
    W. Stroke YES NO
    X. Thyroid YES NO
    Y. Tuberculosis YES NO
    Z. Venereal Disease YES NO
    AA. Other _____

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware of.

I have reviewed the health history form above.

Patient Signature: _____ Date: _____ Doctor Signature: _____ Date: _____