Amsterdam Oral Surgery & Dental Implant Center

Patient Information

Patient's Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: M / F Soc. Sec. #:_____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Driver's License #: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ (circle one) Married, Single, Divorced, Widowed

Spouse's Name: _____ Spouse's Work Phone: _____

Responsible Party's Name: _____ Phone: _____
(If Patient is Under Age 18)

Responsible Party's Relationship to patient: _____

Responsible Party's Address_____

Referring Dentist: _____ Physician: _____

Reason for Visit: _____

Dental Insurance Information

Name of Insured: _____ Soc. Sec. # _____

Relationship to Insured: _____ Date of Birth: _____

Address: _____Phone Number: _____

City: _____ State: _____ Zip: _____

Name of Insurance: _____ Group #: _____

Employer: _____ Phone #: _____

Medical Insurance Information

Name of Insured: _____ Soc. Sec. # _____

Relationship to Insured: _____ Date of Birth: _____

Address: _____Phone Number: _____

City: _____ State: _____ Zip: _____

Name of Insurance: _____ Group #: _____

Employer: _____ Phone #: _____

Secondary Insurance Information

Name of Insured: _____ Soc. Sec. # _____

Relationship to Insured: _____ Date of Birth: _____

Address: _____Phone Number: _____

City: _____ State: _____ Zip: _____

Name of Insurance: _____ Group #: _____

Employer: _____ Phone #: _____

Personal Payment Type: Please circle: Cash Check Credit Card

Signature of Patient or Responsible Party: _____

HEALTH HISTORY

Patient's Name | Age | Date of Birth | Today's Date

Pharmacy Name & Location

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

   _____
   _____
   _____
   _____
   _____
   _____
   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ..... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list ..... Y N

     _____
     _____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date | Signature of Person Completing Health History | Doctor's Initials

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

Exam Authorization

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

_____	_____	_____
Patient Printed Name	Patient Signature	Date

_____
Witness Signature

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me.
I have been given the opportunity to ask any questions I may have regarding this Notice.

_____	_____	_____
Patient Printed Name	Patient Signature	Date