WHEAT RIDGE ORAL SURGERY

Patient's Name ______ Date of Birth ______ Age ______ Height ______ Weight ______ Date ______

Answer all questions by circling YES (Y) or No (N). All responses are kept confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your general health in the past year? .... Yes No
3. Date of last physical exam ____________________
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? ____________________
5. The name and address of my physicians are:

	Name	Address	Phone #
Primary Care MD:			
Specialists:			

6. Have you had any serious illnesses, operations or hospitalizations? .... Yes No
   If so, describe ____________________
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc)? .... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? .... Yes No
9. Please list **ALL** medications you are currently taking including diet pills, non-prescription, vitamins, homeopathic or natural remedies ____________________
   ____
   ____
   ____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur? .... Yes No
    b. Rheumatic Heart Disease? .... Yes No
    c. High Blood Pressure? .... Yes No
    d. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition including bypass surgery or stent placement? (circle) .... Yes No
       1. Chest pain upon exertion? .... Yes No
       2. Shortness of breath after mild exercise? .... Yes No
       3. Do your ankles swell? .... Yes No
    e. Sinus Trouble? .... Yes No
    f. Asthma or hay fever? .... Yes No
    g. Diabetes? .... Yes No
    h. Frequent or recurring mouth sores? .... Yes No
    i. Thyroid problems? .... Yes No
    j. Arthritis? .... Yes No
    k. Osteoporosis? .... Yes No
    l. Stomach ulcer or hyperacidity or GERD? (circle) .... Yes No
    m. Tuberculosis? .... Yes No
    n. Cancer? .... Yes No
    o. Radiation (X-ray) treatment for cancer? .... Yes No
    p. Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)? (circle) .. Yes No
    q. Seizures, convulsions, epilepsy, fainting or dizziness? .... Yes No
    r. Bleeding disorder, anemia, bleeding tendency, blood transfusion? .... Yes No
    s. Liver disease (jaundice, hepatitis)? .... Yes No
    t. Kidney disease? .... Yes No
    u. Implants placed anywhere in your body (heart valve, pacemaker, hip, knee)? .... Yes No
    v. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth, "TMJ"? (circle) .... Yes No

POS Reorder # 1602524

w. Any disease, drug or transplant operation that has depressed your immune system? ... Yes No
x. Glaucoma? ... Yes No
y. HIV, AIDS or ARC? ... Yes No

11. Have you ever had treatment for a tumor or growth? ... Yes No
12. Have you had radiation therapy to the head, neck or jaws? ... Yes No
13. Are you allergic to or have you had a reaction to:
    a. Local anesthetics (Novocaine, etc.)? ... Yes No
    b. Penicillin or antibiotics? ... Yes No
    c. Sulfa drugs? ... Yes No
    d. Barbiturates or sleeping pills? ... Yes No
    e. Aspirin? ... Yes No
    f. Iodine? ... Yes No
    g. Codeine or other narcotics? ... Yes No
    h. Latex or rubber products? ... Yes No
    i. Other ____________________ Yes No
14. Have you had any serious trouble associated with previous dental treatment? ... Yes No
    If so, please explain ____________________
    ____
15. Do you have any other condition or disease you think the doctor should know about? ... Yes No
16. Do you smoke or chew Tobacco? ... Yes No
    How Much? ____________________
17. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ... Yes No
18. Do you take any marijuana, cocaine, or other "recreational" drugs? ... Yes No
19. Have you or an immediate family member had any problem associated with intravenous anesthesia? ... Yes No
20. Do you wish to talk with the doctor privately about anything? ... Yes No
21. **FOR WOMEN ONLY**
    a. Are you taking birth control pills? ... Yes No
    b. Are you pregnant, or **is there any chance** you might be pregnant? ... Yes No
    c. Are you breast feeding? ... Yes No
    d. **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 have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely. I understand the importance of a truthful and complete Health History and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Date	Signature of Person Completing Health History	Doctor's Initials

(Do Not Write Below This Line)

MEDICAL UPDATE: I have reviewed my health history dated ____________ and confirm that it accurately states past and present conditions.

Exceptions: ____________________
____
____

Date	Signature of Person Completing Health History	Doctor's Initials

WHEAT RIDGE ORAL SURGERY

Confidential Information

(Mr., Mrs., Ms., Dr.) First Name __________________ M.I. ____ Last Name ______________________
Address ____ Apt #______________
City ____ State ______________ Zip________________
Home Phone # _________________ Cell # __________________ Email __________________________
Birthdate _________________ Age______ M_____ F_____ Married ______ Single _______
Social Security #______________________________ Drivers License # _______________________
Employer ____ Work # _______________
Spouse's Name ____
Spouse's Employer ____ Work # _______________
If a Minor, Parent's Name ____
Address ____ Apt #______________
City ____ State ______________ Zip________________
Reason for Being Referred to Our Office ____
Family Members Who Have Been Patients ____
Student Full Time Part Time Not School Name/Address ________________________________
Referred By _____________________________ Family Dentist _______________________________

Insurance Information

Dental

Insurance Company ____
Mailing Address ____
____
Name of Insured____
ID or Social Security #____
Policy/Group #_______________________________ Insured's Birthdate________________________
Name of Employer_____________________________________ Work Phone # ____________________
Relationship to Patient Self ________ Spouse ________ Parent ________ Guardian _________

Medical

Insurance Company ____
Mailing Address ____
____
Name of Insured____
ID or Social Security #____
Policy/Group #_______________________________ Insured's Birthdate________________________
Name of Employer_____________________________________ Work Phone # ____________________
Relationship to Patient Self ________ Spouse ________ Parent ________ Guardian _________

The information above is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I hereby authorize Wheat Ridge Oral Surgery to furnish my insurance company information concerning my (or my dependent's) treatment and I hereby assign Wheat Ridge Oral Surgery all payments for dental and/or medical services rendered to myself or my dependent. I understand and agree that Wheat Ridge Oral Surgery is not aware nor could reasonably be expected to know that the services they are rendering to me are a covered or a non-covered benefit of my insurance. I agree to pay Wheat Ridge Oral Surgery for the services rendered to me. I may choose to seek reimbursement from my insurance company, realizing that the cost of services may or may not be a benefit.

____
Patient/Responsible Party Signature Date