MCLEAN ORAL, FACIAL & IMPLANT SURGERY

WELCOME TO OUR PRACTICE

Patient:

(Mr___Mrs___ Dr___Ms___) First_____ M.I._____ Last_____

Sex: Male_____ Female_____ Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Date of Birth _____Age_____ Social Security #_____-____-_____ Referred By_____

Who will be responsible for account? Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐

Emergency Contact:

Name _____ Relationship: _____ Home Telephone (_____)_____

Home Address:

Street_____ City_____ State_____ Zip_____

Home Telephone (_____)_____Email Address_____

Referral:

Name of Referring Dentist or Provider: _____ Address: _____

Name of General Dentist: _____ Address: _____

Employment History or School:

Employer or School Name _____

Business Address_____

Business Telephone (_____)_____Plan Name_____

Primary Dental Insurance Company

Ins. Co. Name_____

Address_____ Telephone (____)_____

ID #_____Group # _____

Insured Party_____ Relation_____

Subscriber's Date of Birth_____ Soc. Sec. #_____

Primary Medical Insurance Company

Ins. Co. Name_____

Address_____ Telephone (_____)_____

ID#_____ Group#_____

Insured Party_____ Relation_____

Date of Birth_____ Soc. Sec. #_____

MCLEAN ORAL, FACIAL & IMPLANT SURGERY

WELCOME TO OUR PRACTICE

To our patients:

Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Height_____ Weight_____ Age_____

Have you had any illness, operation or been hospitalized in the past five years? _____

Is there any condition concerning your health or your family's anesthetic history that the doctor should be told? _____

Do you have a prosthetic joint or valve? Yes_____ No_____

Do you smoke or chew tobacco? Yes_____ No_____

Do you consume alcoholic beverages? Yes_____ No_____

Medications: Please list all medications, drugs, pills, or herbs you are currently taking:

_____

Allergies: Please list all allergies you have including **Penicillin, Aspirin and Eggs or Egg products**:

_____

Women:

Is there a possibility that you may be pregnant? Yes_____ No_____

Are you nursing? Yes_____ No _____

Have you had or do you currently have…	**Yes**	**No**	**Have you had or do you currently have…**	**Yes**	**No**
Prosthetic Heart Valve			Stroke		
Congenital Heart Disease			Thyroid Trouble		
Previous Endocarditis			Diabetes		
High Blood Pressure			Low Blood Sugar		
Cardiac Transplant			Kidney Trouble		
Chest Pain, Angina			Are you on Dialysis		
Heart Attack			Swollen ankles, Arthritis or Joint Disease		
Irregular Heart Beat			Stomach Ulcer		
Cardiac Pacemaker			Contagious Disease		
Heart Surgery			Sexually Transmitted Disease		
Bronchitis, Chronic Cough			Problems of the Immune System		
Asthma			A tumor or Growth		
Hayfever / Sinus Problems			Mental Health Problems		
Tuberculosis			Are you wearing a removable dental appliance		
Emphysema			Are you on a diet		
Difficulty Breathing			Are you taking Bisphosphonates (Fosamax, etc.)		
Blood Transfusion			Contact Lenses		
Blood Disorder such as Anemia			Eye Disease / Glaucoma		
Bruise Easily			Radiation Treatment / Chemotherapy		
Abnormal Bleeding Tendency			Pain and Clicking of the Jaws		
Jaundice, Hepatitis or Liver Disease			Malignant Hyperthermia		
Infectious Mononucleosis			Convulsions / Epilepsy		

I certify that I have read and understand the questions above. I will not hold my surgeon or any members of his / her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: _____ **Date:** _____