HISTORY AND PHYSICAL

NAME: _____ **Date Completed:** _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N). All responses are kept confidential.

Chief Complaint (reason for your visit):_____

_____

Are you in good Health?..... Y N

Has there been any change in your general health in the past year?..... Y N

Date of last Physical Exam_____

Are you now under a Physicians care for a particular problem?..... Y N

If so, please describe_____

_____

_____

Have you had any serious illnesses, operations or hospitalizations

If so, please describe_____

_____

Have you ever had any adverse effects from Dental Treatment? ..... Y N

If so, please describe_____

_____

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD:

Rheumatic Fever or Rheumatic Heart Disease?..... Y N

Congenital Heart Disease?..... Y N

Cardiovascular Disease (heart trouble,heart attack,heart murmur,coronary artery disease,angina,high blood pressure stroke,palpitations,heart surgery or pacemaker)?..... Y N

Lung Disease (asthma,emphysema,chronic cough,bronchitis pneumonia,tuberculosis,shortness of breath,chest pain, severe coughing?..... Y N

Seizures,convulsions,epilepsy, fainting,psychiatric treatment dizziness,nervous disorder or breakdown?..... Y N

Bleeding Disorder,anemia,bleeding tendency,blood transfusion or do you bruise easily?..... Y N

Liver Disease (jaundice,hepatitis)?..... Y N

Kidney Disease?..... Y N

Diabetes?..... Y N

Thyroid Disease (Goiter)?..... Y N

Arthritis?..... Y N

Stomach Ulcers or Colitis?..... Y N

Glaucoma?..... Y N

Frequent or recurring mouth sores?..... Y N

Implants placed anywhere in your body?..... Y N

If so, please describe_____

_____

Radiation (X-ray) treatment for Cancer?..... Y N

WOMEN:

Are you pregnant or planning pregnancy?..... Y N

Are you taking birth control pills?..... Y N

Are you taking hormone replacements?..... Y N

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD:

Clicking or Popping of the jaw joint,pain near ear, difficulty opening mouth,grind or clench teeth?..... Y N

Sinus or nasal problems?..... Y N

Any disease,drugs or transplant operation that has depressed your immune system?..... Y N

Recurrent infections of any kind?..... Y N

ARE YOU USING OR TAKING ANY OF THE FOLLOWING:

Tagamet?..... Y N

Thyroid medications?..... Y N

Antibiotics or sulfa drugs?..... Y N

Anticoagulants (blood thinner(s))?..... Y N

High Blood Pressure medicine?..... Y N

Steroids (Cortisone, etc.)?..... Y N

Tranquilizers (Valium, etc.)?..... Y N

Insulin, Diabetese or similar drugs?..... Y N

Digitalis, Inderal, Nitroglycerin, Calcium channel blockers, Procardia or other heart medicine?..... Y N

Aspirin or ibuprofen (motrin, naprosyn, etc)?..... Y N

If so, how much daily_____

Marijuana or other "street drugs"?..... Y N

Antihistamines or decongestants (Seldane)?..... Y N

Herbal/Over-the-Counter medications, pills or drugs? Y N

Are you taking any of the Bisphosphonate family of drugs (Aredia, Zometa, Fosamax, Actonel)?..... Y N

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO:

Penicillin, Amoxicillin, cephalosporins or other antibiotics?..... Y N

Local anesthetic (Novacaine,etc)?..... Y N

Barbiturates,sedatives etc?..... Y N

Aspirin or Ibuprofen?..... Y N

Codeine or other pain killers?..... Y N

Latex or rubber products?..... Y N

If yes, please describe_____

Other allergies/reactions?..... Y N

Please describe_____

Do you smoke or chew tobacco?..... Y N

If so, how much daily?_____

Do you use alcohol?..... Y N

If so, how much daily?_____

Have you ever sought professional care for drug abuse, alcohlism, or emotional disorder?..... Y N

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N

If so, please descibe_____

Have you had any serious problems associated with any previous dental treatment?..... Y N

Have you or an immediate family member had any problems asscoiated with intravenous anesthesia?..... Y N

Do you wish to talk with the doctor privately about anything?..... Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I UNDERSTAND THAT I WILL HAVE THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ /_____

Signature of person completing Health History ***Doctors Initials***

ALAMO MAXILLOFACIAL SURGICAL ASSOCIATES, PA

PATIENT INFORMATION:

Prefix | First | Middle | Last | Suffix | Preferred Name/Nickname

Street/PO Box | City | State | Zip | Male/Female (please circle)

Home Telephone | Work Telephone | Mobile Telephone | Birthdate | Age

Social Security Number | Driver's License Number(State) | Single / Married Marital Status (please circle)

Family Physician | General Dentist | Who Referred You To Our Practice?

Employer | Preferred Pharmacy | Pharmacy Phone Number | Name of School (if a student)

Your Email Address | Emergency Contact | Relationship to Patient | Telephone

RESPONSIBLE BILLING PARTY (must be present with patient):

Prefix | First | Middle | Last | Suffix | Preferred Name/Nickname

Street/PO Box | Apt # | City | State | Zip | Male/Female (please circle)

Home Telephone | Cell Telephone | Work Telephone | Birthdate | Age

Social Security Number | Driver's License Number(State) | Single / Married / Divorced / Widowed Marital Status (please circle)

PRIMARY MEDICAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company | Name of Insured

Insured's ID Number | Insured's Group Number

Insured's SS Number | Insured's Date of Birth

Insured's Employer | Insured's Driver's License

SECONDARY MEDICAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company | Name of Insured

Insured's ID Number | Insured's Group Number

Insured's SS Number | Insured's Date of Birth

Insured's Employer | Insured's Driver's License

PRIMARY DENTAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company | Name of Insured

Insured's ID Number | Insured's Group Number

Insured's SS Number | Insured's Date of Birth

Insured's Employer | Insured's Driver's License

SECONDARY DENTAL INSURANCE:
Relationship to Patient *(please circle)* : Self / Spouse / Parent

Insurance Company | Name of Insured

Insured's ID Number | Insured's Group Number

Insured's SS Number | Insured's Date of Birth

Insured's Employer | Insured's Driver's License

I authorize payment of insurance benefits (including all Commercial, Medicare and Medigap plans) to be issued directly to Alamo Maxillofacial Surgical Assoc. for any services rendered to me. I further authorize Alamo Maxillofacial Surgical Associates to release to my insurance carrier listed above any information necessary to determine benefits payable for related services. I understand that I am responsible for payment of services not covered and/or denied by my insurance carrier and, in the event my insurance company fails to remit payment within 60 days from the date of service, I am responsible for the balance of my account. I understand a service charge of $5-$10 will apply for any balance resulting in collection activities.

Signature of Patient (or Guardian) **Date**

Staff Intake Initials/Date