COLORADO SPRINGS
ORAL & FACIAL SURGERY

Patient Information

Name: _____ Nickname: _____ Date:_____
Address: _____ City, State: _____ Zip Code: _____
Phone: _____ E-mail:_____ DOB: _____
Social Security #: _____Marital Status: _____
Employer: _____ Address: _____ Work Phone:_____
Emergency Contact: _____ Phone: _____ Relationship: _____
Whom may we thank for referring you?_____ Dentist: _____
Physician: _____ Purpose of visit:_____
Person responsible for bill: _____ DOB: _____ SSN: _____
Address: _____ City/State: _____ Zip: _____ Phone: _____

Dental Insurance Co: _____ Group #: _____ Policy #: _____
Address of Insurance: _____ City/State: _____ Zip: _____
Insurance Phone #: _____ Employer: _____
Name of Policy Holder: _____ DOB: _____ SSN: _____

Medical Insurance Co: _____ Group #: _____ Policy #: _____
Address of Insurance: _____ City/State: _____ Zip: _____
Insurance Phone #: _____ Employer: _____
Name of Policy Holder: _____ DOB: _____ SSN: _____
***I authorize the release of medical/dental/other information necessary to process my bill or insurance claim. I authorize payment of medical/dental benefits to Colorado Springs Oral Surgery, PC.

Medical History

Age: ____ Weight:_____ Height: _____ Sex: _____ Conditions for which you have seen a doctor in the last 2 years: _____
Drug allergies (Penicillin, Sulfa, Codeine, etc): _____
Medications you are taking: _____
Serious illnesses: _____ Have you ever had a general anesthetic?_____
What surgeries have you had?_____
_____
Complications with surgery/anesthesia:_____
Is there a possibility you could be pregnant?____ Due date:_____ Any jaw joint (TMJ) problems:_____
Do you smoke? **Y N** How many packs/day?_____ How many years?_____
Do you drink? **Y N** How many drinks/day?_____ How many years?_____
Do you have a history of or currently use recreational drugs? (Marijuana, Cocaine, Heroine, etc):_____

Do you have a history of, or are you suffering from any of the following?
Y N Previous stroke/TIA _____
Y N Heart trouble _____
History of Heart attack? **Y N** When?_____
Y N Chest pain _____How often?_____

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Medical History Cont.

Y N High/low blood pressure _____
Y N Heart murmur _____
Y N Rheumatic Fever _____
Y N Diabetes _____If yes, then do you take insulin? **Y N**
Y N Endocrine/Thyroid problem _____
Y N Sinus trouble _____
Y N Asthma _____Frequency of inhaler use?_____
If yes, then have you ever been hospitalized for your asthma? **Y N**
Y N Emphysema/Bronchitis_____
Y N Sleep Apnea _____Do you use CPAP: **Y N**
Y N Stomach Trouble _____
If yes, have you been told by a physician to not take Ibuprofen? **Y N**
Y N AIDS/HIV _____
Y N Anemia _____
Y N Bleeding Disorder _____
Y N Treatment of Tumor/Cancer _____Have you had radiation? **Y N**
Y N Kidney condition _____
If yes, have you been told by a physician to not take Ibuprofen? **Y N**
Y N Liver condition _____
If yes, have you been told by a physician to not take Tylenol? **Y N**
Y N Joint Replacement _____
If you have had a total joint replacement, how long ago was your last joint replacement?_____
Y N Epilepsy/Seizures _____If yes, then how often?_____
Y N Alcohol abuse _____
Y N Hepatitis _____
Y N Previous use of Fen-Phen
Y N Psych condition/Depression/Anxiety/Bipolar (circle applicable)

Y N Current or previous use of **Xgeva/Denosumab/Amgen** or **Avastin/Bevacizumab** (cancer chemo)
Y N Current or previous use of **Aredia/Pamidronate** or **Zometa/Zoledronate** (cancer chemo)
Y N Current or previous use of **Fosamax, Actonel, Reclast, Boniva, Didronel** or **Skelid** for osteoporosis
If yes to the previous 3 questions, do you still take the medication, or when did you stop it?
_____

Signature of Patient or Parent/Guardian:_____

Reviewed by Dr. _____