ORAL SURGERY SPECIALISTS OF PUEBLO

Patient Information

Purpose of visit: _____ Date: _____/_____/_____

Patient Name: (First) _____ (Middle Initial) _____ (Last) _____
Preferred Name: _____ ❒Male ❒Female DOB: _____/_____/_____
Mailing Address: _____City:_____State:_____ Zip: _____
Physical Address: _____City:_____State:_____ Zip: _____
Phone: _____ Social Security #:_____
Employer: _____
Personal Email: _____

Legal Parent/Guardian Name: _____ DOB: _____/_____/_____
Address: _____City:_____State:_____ Zip: _____
Phone: _____ Social Security #:_____
Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____
Relation to Patient: _____

Dentist: _____ Office Phone #: _____
Physician: _____ Office Phone #: _____

Insurance Information

Dental Insurance Co: _____ Member ID#/Policy#: _____
Group#: _____ Ins. Co. Address: _____
City: _____ State: _____ Zip: _____ Ins. Co. Phone #: _____
Name of Policy Holder: _____ DOB: _____/_____/_____
Social Security #:_____ Relation to Patient: _____

Medical Insurance Co: _____ Member ID#/Policy#: _____
Group#: _____ Ins. Co. Address: _____
City: _____ State: _____ Zip: _____ Ins. Co. Phone #: _____
Name of Policy Holder: _____ DOB: _____/_____/_____
Social Security #:_____ Relation to Patient: _____

Pharmacy Information

Preferred Pharmacy: _____ Pharmacy Address: _____

*****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. *****

_____

Patient / Parent / Legal Guardian Signature **Date**

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Medical Health History

Patient Name: _____ Age: _____ Weight: _____ Height: _____

Allergies

❒Aspirin ❒Penicillin ❒Amoxicillin ❒Clindamycin ❒Codeine

❒Sulfa Drugs ❒Latex ❒Other _____ **❒None known**

Check ALL current or past medical conditions and habits:

❒ High Blood Pressure ❒ Blood Thinners ❒ Chest Pain ❒ Asthma – **NOTE bring inhaler to surgery** ❒ Difficulty Breathing ❒ Emphysema/Bronchitis ❒ Sleep Apnea ❒ Previous use of Fen-Phen ❒ Thyroid issues Could you be, or are you pregnant? ❒ Y ❒ N	❒ Diabetes - **NOTE bring insulin machine to surgery** ❒Type 1 ❒Type 2 ❒ Non-Healing Wounds ❒ Liver Disease ❒ Bruise Easily / Hemophilia ❒ Kidney Disease ❒ Seizures / Convulsions ❒ Psych Condition/Depression/Anxiety/Bipolar
❒ Artificial Heart Valve ❒ Congenital Heart Defect ❒ Rheumatic Fever ❒ Heart Infection ❒ Heart Disease / Heart Attack ❒ Pacemaker ❒ Artificial Joint ❒ Take Antibiotics before Dental Appointments	**Alcohol** - For _____ yrs. How much: _____ How often: _____ **Cigarettes** - For _____ yrs. How much: _____ How often: _____ **Marijuana** - For _____ yrs. How much: _____ How often: _____ **Other Drugs**:_____ For _____ yrs. How much: _____ How often: _____
❒ Hepatitis ❒A ❒B ❒C ❒D ❒E ❒ Herpes ❒Type 1 ❒Type 2 ❒ HIV / AIDS	❒ Radiation to Jaw / Head / Neck ❒ Osteoporosis ❒ Bone Hardening Medications / IV Bisphosphonates ❒ Cancer / Chemotherapy

Do you have any other current or past medical conditions and or habits not listed? ❒Y ❒N

If yes, please list: _____

When did you last see a primary care doctor? _____

What surgeries have you had? _____

Have you ever had a general anesthesia (been put to sleep) before? ❒ Y ❒ N

Have you had complications with surgery/anesthesia? _____

Do you have a family history of complications with anesthesia? ❒ Y ❒ N

_____

Patient / Parent / Legal Guardian Signature **Date**

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Medication Information

Patient Name: _____ DOB: _____/_____/_____

Please list ALL medications you are taking or please provide a list

Medication Name	Dosage	Instructions	Frequency

Whom may we thank for referring you? _____

_____

Patient / Parent / Legal Guardian Signature **Date**