Patient Intake Form

Oral & Facial Surgery

☐ Mr ☐ Mrs ☐ Ms ☐ Dr First _____ M.I. _____ Last _____ Nickname _____
☐ Male | ☐ Female Social Security Number _____ Date of Birth _____ / _____ / _____ Age _____
Address _____ Drivers License Number _____
City _____ State _____ Zip _____ Email _____
Home Phone _____ Work Phone _____ Cell Phone _____
Marital Status ☐ Single | ☐ Married | ☐ Other Spouse's Name (if applicable) _____
Name(s) of any family/friends who have been a patient here _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Employment

Employment Status ☐ Full Time | ☐ Part Time | ☐ Student | ☐ Retired | ☐ Other _____
Employer _____ Occupation _____

Education

Student Status ☐ Full Time | ☐ Part Time | ☐ Other _____
School _____ Grade Level _____

Referral

General Dentist _____ Orthodontist _____
Primary Care Physician _____ Other Healthcare Providers _____
Pharmacy _____ Pharmacy Phone _____

Guarantor

Who is responsible for payment? ☐ Self | ☐ Spouse | ☐ Parent | ☐ Other _____
Guarantor _____ DOB _____ SSN _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone _____ Home Phone _____ Cell Phone _____

Insurance

Primary Dental Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____
Primary Medical Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____
Secondary Insurance _____ Policy # _____ Group # _____
Name of Insured _____ DOB _____ SSN _____

How did you hear about us ☐ Dentist | ☐ Friend/Family | ☐ Facebook | ☐ Print Ad | ☐ Internet Search
☐ Insurance | ☐ Other _____

I have read and understand the questions and information I provided above and on the Patient Health History following. I acknowledge that my questions, if any, about the inquiries concerning my information and/or my health history have been answered to my satisfaction. I will not hold OFS, LLC or its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Patient Signature Date Parent/Guardian Signature Date

Patient Health History

For your safety, it is necessary that you answer all of the following questions. (This information is strictly confidential)
Patient Name _____ Weight _____ Height _____

Past Medical History

Do you have a Latex allergy? ☐ Yes | ☐ No
Do you have any food allergies? ☐ Yes | ☐ No If yes, please explain _____
Do you have any known drug allergies? ☐ Yes | ☐ No If yes, please explain _____
Please list all medications (including prescriptions, over the counter medicines, vitamins, herbal supplements, and/or dietary supplements)

_____

_____

Are you currently taking or have you ever taken:

- Aspirin containing medications ? ☐ Yes | ☐ No List _____ Date last taken ____/____/____
- Blood thinners (warfarin, Coumadin, Xarelto, etc)? ☐ Yes | ☐ No List _____ Date last taken ____/____/____
- Bisphosphonate (Fosomax, Boniva, Reclast, etc) ☐ Yes | ☐ No List _____ Date last taken ____/____/____
- Steroids (prednisone, Kenalog, etc)? ☐ Yes | ☐ No List _____ Date last taken ____/____/____
- Birth control pill or hormone replacement therapy? ☐ Yes | ☐ No List _____ Date last taken ____/____/____

Are you pregnant or are you planning to become pregnant within the next year? ☐ Yes | ☐ No

Do you have or have you ever had? (Please circle Y=Yes or N=No)

Y | N High Blood Pressure	Y | N Rheumatic Fever	Y | N Arthritis	Y | N Unexplained Weight Change
Y | N Heart Attack	Y | N Sinus Problems	Y | N Kidney Disease	Y | N Thyroid Disease
Y | N Irregular Heart Beat	Y | N Obstructive Sleep Apnea	Y | N Anemia	Y | N Depression
Y | N Chest Pain	Y | N Shortness of Breath	Y | N Sickle Cell Disease	Y | N Depressed Immune System
Y | N Heart Murmur	Y | N Asthma	Y | N Bleeding Problems	Y | N Psychiatric Diagnosis
Y | N Congenital Heart Lesions	Y | N Emphysema	Y | N Stroke	Y | N Herpes (cold sores)
Y | N Prosthetic Heart Valve	Y | N Tuberculosis/PPD Positive	Y | N Painful joints	Y | N HIV/AIDS
Y | N Pacemaker	Y | N Stomach Ulcers or Colitis	Y | N Prosthetic Joint(s)	Y | N STD
Y | N Epilepsy or Seizures	Y | N G-6PD deficiency	Y | N Headaches (Migraine)	Y | N Cancer/Radiation Therapy
Y | N Glaucoma	Y | N Liver Disease	Y | N Eating Disorder	Y | N Other _____
Y | N Nose Obstruction	Y | N Hepatitis	Y | N Diabetes	Y | N Other _____

Past Surgical History

Please list all prior surgeries and any associated complications _____
Is there a personal or family history of anesthetic complications or malignant hyperthermia? ☐ Yes | ☐ No
If yes, please explain _____

Family History

Do you have a family history of any medical problems? (Please check all that apply)

☐ High Blood Pressure	☐ Obstructive Sleep Apnea	☐ Bleeding Problems	☐ Diabetes
☐ Heart Disease	☐ Seizures	☐ Stroke	☐ Thyroid Disease

Social History

Do you or have you ever smoked tobacco products? ☐ Yes | ☐ No If yes, packs/day _____ for _____ years _____ last/quit
Do you drink alcohol? ☐ Yes | ☐ No If yes, please check? ☐ Occasional | ☐ Moderate | ☐ Daily
Do you or have you used recreational drugs? ☐ Yes | ☐ No If yes, please list _____

_____ _____ _____ _____
Patient/Parent/Guardian Signature Date Staff Signature Date