ORAL SURGERY/IMPLANT CONSULTATION

This questionnaire was designed to provide important facts regarding the history of your pain or condition The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/ PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/ PROV. _____ ZIP/ P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

FAMILY PHYSICIAN _____

ADDRESS _____

FAMILY DENTIST _____

ADDRESS _____

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

Yes ☐ No ☐ Diet limited to semisolid food or soft foods
Yes ☐ No ☐ Diet limited to liquid foods
Yes ☐ No ☐ Difficulty chewing
Yes ☐ No ☐ Difficulty speaking
Yes ☐ No ☐ Difficulty swallowing
Yes ☐ No ☐ Digestive problems
Yes ☐ No ☐ Facial pain
Yes ☐ No ☐ Gagging easily
Yes ☐ No ☐ Head pain
Yes ☐ No ☐ Jaw clicks
Yes ☐ No ☐ Jaw locks
Yes ☐ No ☐ Limited opening of jaw
Yes ☐ No ☐ Loss of teeth
Yes ☐ No ☐ Are you currently in pain? _____
Yes ☐ No ☐ Do you feel your oral condition is affecting your general health in any way? _____

Yes ☐ No ☐ Mouth sores
Yes ☐ No ☐ Numbness in lower lip
Yes ☐ No ☐ Numbness in jawbone
Yes ☐ No ☐ Tingling in jawbone
Yes ☐ No ☐ Nutritional disorders
Yes ☐ No ☐ Pain in jaw bone
Yes ☐ No ☐ Pain in jaw joint
Yes ☐ No ☐ Pain when swallowing
Yes ☐ No ☐ Pain when chewing
Yes ☐ No ☐ Poorly fitting dental appliance ☐ upper ☐ lower
Yes ☐ No ☐ Teeth do not meet properly
Yes ☐ No ☐ Other

Patient Signature _____ Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- N ☐ Antibiotics
- N ☐ Aspirin
- N ☐ Barbiturates
- N ☐ Codeine
- N ☐ Iodine
- N ☐ Latex
- N ☐ Local anesthetics
- N ☐ Other _____

- Y ☐ N ☐ Metals
- Y ☐ N ☐ Penicillin
- Y ☐ N ☐ Plastic
- Y ☐ N ☐ Sedatives
- Y ☐ N ☐ Sleeping pills
- Y ☐ N ☐ Sulfa drugs

_____ _____

IST ANY MEDICATIONS CURRENTLY BEING TAKEN:

- N ☐ Antibiotics
- N ☐ Anticoagulants
- N ☐ Barbiturates
- N ☐ Blood thinners
- N ☐ Codeine
- N ☐ Cortisone
- N ☐ Diet pills
- N ☐ Heart medication
- N ☐ Other _____

- Y ☐ N ☐ Insulin
- Y ☐ N ☐ Muscle relaxants
- Y ☐ N ☐ Nerve pills
- Y ☐ N ☐ Pain medication
- Y ☐ N ☐ Sleeping pills
- Y ☐ N ☐ Sulfa drugs
- Y ☐ N ☐ Tranquilizers

_____ _____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:

Practitioner	Specialty	Treatment & Approximate date

MEDICAL HISTORY (Please indicate dates on questions checked YES)

- Y ☐ N ☐ Abnormal bleeding after surgery or injury
- Y ☐ N ☐ Anemia
- Y ☐ N ☐ Arteriosclerosis
- Y ☐ N ☐ Asthma
- Y ☐ N ☐ Autoimmune disorders
- Y ☐ N ☐ Bleeding easily
- Y ☐ N ☐ Bloating
- Y ☐ N ☐ Blood pressure ☐ High ☐ Low
- Y ☐ N ☐ Bruising easily
- Y ☐ N ☐ Cancer
- Y ☐ N ☐ Chemotherapy
- Y ☐ N ☐ Chronic Bronchitis
- Y ☐ N ☐ Chronic fatigue
- Y ☐ N ☐ Chronic mouth dryness
- Y ☐ N ☐ Cold hands & feet
- Y ☐ N ☐ Colitis
- Y ☐ N ☐ Current pregnancy
- Y ☐ N ☐ Depression
- Y ☐ N ☐ Diabetes
- Y ☐ N ☐ Dizziness
- Y ☐ N ☐ Emphysema
- Y ☐ N ☐ Epilepsy
- Y ☐ N ☐ Excessive thirst
- Y ☐ N ☐ Fainting spells
- Y ☐ N ☐ Fluid retention
- Y ☐ N ☐ Frequent cough
- Y ☐ N ☐ Frequent illnesses
- Y ☐ N ☐ Frequent stressful situations
- Y ☐ N ☐ General anesthesia
- Y ☐ N ☐ Glaucoma
- Y ☐ N ☐ Gout
- Y ☐ N ☐ Hay fever
- Y ☐ N ☐ Headaches
- Y ☐ N ☐ Hearing impairment
- Y ☐ N ☐ Heart murmur
- Y ☐ N ☐ Heart disorder
- Y ☐ N ☐ Heart pacemaker
- Y ☐ N ☐ Heart palpitations
- Y ☐ N ☐ Heart valve replacement
- Y ☐ N ☐ Hemophilia
- Y ☐ N ☐ Hepatitis
- Y ☐ N ☐ Hypoglycemia
- Y ☐ N ☐ Immune system disorder
- Y ☐ N ☐ Injury to
  - ☐ Face ☐ Mouth
  - ☐ Neck ☐ Teeth
- Y ☐ N ☐ Insomnia
- Y ☐ N ☐ Intestinal disorders
- Y ☐ N ☐ Jaw joint surgery
- Y ☐ N ☐ Kidney problems
- Y ☐ N ☐ Liver disease
- Y ☐ N ☐ Meniere's disease
- Y ☐ N ☐ Menstrual cramps
- Y ☐ N ☐ Multiple sclerosis
- Y ☐ N ☐ Muscle aches
- Y ☐ N ☐ Muscle shaking (tremors)
- Y ☐ N ☐ Muscle spasms or cramps
- Y ☐ N ☐ Muscular dystrophy
- Y ☐ N ☐ Needing extra pillows to help breathing at night
- Y ☐ N ☐ Nervous system irritability
- Y ☐ N ☐ Nervousness
- Y ☐ N ☐ Neuralgia
- Y ☐ N ☐ Osteoarthritis
- Y ☐ N ☐ Osteoporosis
- Y ☐ N ☐ Ovarian cysts
- Y ☐ N ☐ Parkinson's disease

Other _____

Patient Signature _____ Date _____

MEDICAL HISTORY Continued

Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever

Y☐ N☐ Shortness of breath
Y☐ N☐ Sickle Cell Anemia
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stomach ulcers
Y☐ N☐ Stroke

Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
  Y☐ N☐ Frequent Colds
  Y☐ N☐ Ear Infections
  Y☐ N☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders

Y☐ N☐ Other Medical/Dental History _____

Do you take aspirin regularly ☐ Yes ☐ No Smoke tobacco ☐ Yes ☐ No

Has any close relative had a serious illness or condition ☐ Yes _____ ☐ No

Emotional or nervous disturbances? ☐ Yes ☐ No

If yes, please explain _____

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THIS VISIT

THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

☐ A motor vehicle accident
☐ A motorcycle accident
☐ A work related incident
☐ A playground incident
☐ An athletic endeavor
☐ A fight
☐ A fall
☐ An accident
☐ Unknown
☐ Other _____

DATE OF ACCIDENT OR INCIDENT: _____

HISTORY OF ACCIDENT

WERE YOU ?

☐ A passenger in a vehicle
☐ The driver of a vehicle
☐ A pedestrian
☐ At work

☐ Did you fall?
☐ Were you hit by an object?
☐ Did you hit an object?
☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

☐ At front end
☐ At rear end
☐ At front right area
☐ At front left area
☐ At rear right area
☐ At rear left area

☐ Head on
☐ On driver's side
☐ On passenger's side
☐ Other _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA:

DID YOUR

☐ Forehead
☐ Face
☐ Chin
☐ Side of head
☐ Back of head
☐ Top of head
☐ Teeth
☐ Jaw
☐ Other _____

FORCIBLY STRIKE

☐ Steering wheel
☐ Windshield
☐ Passenger's side window
☐ Driver's side window
☐ Passenger's side door
☐ Driver's side door
☐ Headrest
☐ Seat
☐ Roof
☐ Interior of car
☐ Other _____

TEETH WERE

☐ Sore
☐ Missing
☐ Loose
☐ Broken
☐ Other _____

AFTER THE ACCIDENT

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

FOR OFFICE USE

Extent of medical history obtained on _____ *(date)* *consisted of:*

☐ Chief Complaint(s) ☐ Extended history of present illnesss
☐ Review of systems related to problem ☐ Review of all additional body systems
☐ Complete past history ☐ Complete family history ☐ Complete social history

Patient Signature _____ Date _____

H.I.P.P.A. Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. if the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature:_____ Date:_____
Patient, parent or legal guardian

If signed by patient representative, state relationship to patient_____