Oral Surgery Department

Health History Form

(PLEASE PRINT)

Date___________________

PATIENT INFORMATION:

Patients Name: Last____________________________________ **First**_________________________________ **M.I.**______

Birthdate _______/_________/________ **Height**______________ **Weight** ________________ **Age**________________

Address____ **City**_________________________**Zip**____________

***Home phone** _________________________ **Cell** ______________________________ **Work** ________________________**ext**______

Patients social security Number _______-______-________ **Email address**____

*Please list the name of your driver today _______________________________ Drivers phone #_______________________

Financially Responsible Person: (must be filled out completely)

a. Name_______________________________________ Cell #______________________ relation to pt _______________

b. Address ____ City______________________ zip__________________

c. Employer __________________________ Occupation _________________ Work # ____________________________

d. SSN#______________________________________ Drivers license #____

Insurance Information:

.

Insured's name ____________________________________ **Insured's SS**_______-________-_________

Insurance Company _______________________________________ **Group** __________________ **Local #**_________________

Insurance Phone # __________________________________

Dual Coverage? If yes :

Insured's name ____________________________________ **Insured's SS**_______-________-_________

Insurance Company _______________________________________ **Group** __________________ **Local #**_________________

Insurance Phone # __________________________________

Please **INDIVIDUALLY** circle the appropriate answer to each question completely and accurately.
Answers for our records are strictly for our office and are confidential.

Part A. General Health Questions

1. Are you in good health?... Yes No
2. Are you having pain or discomfort at this time?.. .Yes No
3. Have there been any changes in your general health in the past year?....... Yes No
If so, what? ____
4. Have you been under the care of a medical doctor during the past 2 years? Yes No
If so, for what are you being treated? ________________________________

5. Last visit to a medical doctor? Date? ______________________
6. Have you been a patient in the hospital? Yes No
Reason: ____________________________ Date ______________
Reason: ____________________________ Date ______________
Reason: ____________________________ Date ______________

Part B. Medical Conditions- Indicate which of the following have had previously or currently

1. Heart-----------------------------------
a. Heart Failure……………..…Yes No
b. Heart Disease……….…….....Yes No
c. Heart Attack……………….....Yes No
d. Irregular Heart Beat……....Yes No
e. Angina Pectoris………..….Yes No
f. Myocardial Infarction.........Yes No
g. Congenital Heart Disease…Yes No
h. Heart Murmur……….…….....Yes No
i. Mitral Valve Prolapse…........Yes No
j. Rheumatic Fever……….........Yes No
k. Arteriosclerosis……………....Yes No
l. Heart Pacemaker……..…......Yes No
m. Stroke …………….....….....Yes No
n. High Blood Pressure……......Yes No
o. Fainting Spells……………....Yes No
p. Heart Surgery (Bypass/Stem).Yes No
q. Damaged Heart Valves……Yes No
r. Artificial Heart Valve……..Yes No

2. Lungs-------------------------------------
a. Emphysema……….….........Yes No
b. Chronic Cough…………….....Yes No
c. Tuberculosis...…….…….…....Yes No
d. Asthma……….…..............Yes No
e. Bronchitis……….……..........Yes No
f. Hay Fever……….……..........Yes No
g. Difficulty Breathing……….Yes No
h. Any Other Lung Trouble…..Yes No
What?___________________________
i. Do you Smoke? …………….....Yes No
if so, for how long? _______________
How many per day? _______________

3. Liver------------------------------
a. Hepatitis A (infectious)..Yes No
b. Hepatits B (serum) ....Yes No
c. Hepatitis C…………….....Yes No
d. Liver Disease...….….….....Yes No
e. Yellow Jaundice……….Yes No

4. Kidney------------------------------
a. Kidney Trouble………..Yes No
b. Dialysis Treatment...…..Yes No

5. Gastrointestinal
a. Ulcers…………………Yes No
b. Diverticulitis…………..Yes No
c. Bowel Problems…...…..Yes No

6. Endocrine
a. Diabetes………………..Yes No
b. Thyroid Problem..……..Yes No
c. Low Blood Sugar……..Yes No
d. Cancer…………………Yes No
e. Cold Sore/Fever Blisters Yes No
f. Other Contagious Diseases…Yes No
g. Glaucoma…………….…..Yes No

7.Prosthesis
a. Artificial Joints (hip, knee) .Yes No
b. Implanted plates, screws, pins etc?...
…..Yes No

8. Surgery
a. Ever had any type of surgery? …
……..Yes No If so, Please list
____
____
____

9. Blood----------------------------
a. Blood Transfusion….Yes No
b. Hemophilia…………Yes No
c. Anemia……………….Yes No
d. Sickle Cell Disease…...Yes No
e. Bruise Easily……..….Yes No
f. Blood Disorder……… Yes No
g. Abnormal Bleeding… Yes No
h. Infectious Mononucleosis Yes No

10. Other---------------------------------
a. Sinus Trouble……….Yes No
b. Cortisone Medicine….Yes No
c. Drug Addiction………Yes No
d. Epilepsy or Seizures…Yes No
e. Radiation Therapy…...Yes No
f. Chemotherapy………..Yes No
g. Nervousness…………..Yes No
h. Tumors………………..Yes No
i. Developmentally Disabled Yes No
j. Allergies or Hives……..Yes No
k. Swollen Ankles………..Yes No
l. Arthritis or Joint Disease…Yes No
m. Delayed Healing………Yes No
n. Mental Health Problems....Yes No
o. Alcohol Addiction….….Yes No
p. Severe Headaches……...Yes No
q. Contact lenses…………Yes No
r. Chronic Fatigue……….Yes No
s. Pain & Clicking in Jaw Joints
………..Yes No
t. Are you on a diet………..Yes No

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Part C. Allergies

Are you allergic to, or have you had a reaction to any of the following?

1. Local Anesthesia? (Novocain, Epinephrine, Penicillin, etc? Yes No; If so, Please explain_______________________________
2. Sodium Pentothal, Valium or Tranquilizers? Yes No; If so, Please explain____
3. Aspirin?....... …………………………………Yes No
4. Codeine or other Narcotics? …………………Yes No
5. Latex? ……………………………………...Yes No
6. Other Medications? …………………………...Yes No Please list____
7. Allergies other than drugs?...............................Yes No Please list____
8. Soybean……………………………………Yes No
9. Egg…………………………………………Yes No

Part D. Medications

1. Are you taking any kind of medication, drug or pills for any purpose? Yes No If so, please explain ___________________________
____
2. Anticoagulants? (Blood thinners, Aspirin, etc.)…………………………… Yes No
3. Tranquilizers? ………………………………………………………………Yes No
4. Cortisone? ……………………………………………………………..Yes No
5. Are you or have you ever taken any recreational or street drugs? ……….Yes No
6. Are you taking any herbal supplements or non-prescription pills?...............Yes No
7. Are you taking or have you ever taken Bisphophonates (Fosmax, Actonel, Aredia or Zometa for osteoporosis, or chemotherapy for multiple myeloma, etc)? ……………………………………………………...Yes No

Part E. Anesthesia

1. Is there any condition or problem concerning your health or family anesthetic history that the doctor should know about? Yes No
2. I can climb a flight of stairs…….(Circle best answer)………..Without resting Resting halfway Resting at the top
3. Do you have Porphyria ………………………………………………………………………………………………Yes No
4. Have you or anyone else in your family has malignant hypothermia or other complications while under general anesthesia. Yes No

Part G. Woman only Anesthesia

1. Is there any possibility that you may be pregnant ………Yes No
2. Are you nursing?..Yes No
3. Are you taking Birth control pills? ....Yes No
4. Have you had a breast Augmentatio surgery?...................Yes No If yes, when? _________________________
5.

Antibiotics (such as penicillin) nay decrease the effectiveness of birth control pill. Consult your physician or gynecologist for assistance regarding additional methods of birth control. **Initial:** _______________

I certify that I have read and understood the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. To the best of my knowledge, all of the proceeding are true and correct. If I ever have any change in my health of if my medications change, I will inform my oral surgeon at the earliest possible time. I will not hold Dr Hou, Dr Apel or any staff responsible for any errors or omissions that I have made in completion of this form.

____ ____

Signature of Patient/ Parent or Guardian Date Doctors Signature Date

Financial Policy Agreement

Re: Private insurance coverage

We are pleased to extend the COURTESY of billing your insurance company for you. In order to provide you this service, we must have your complete cooperation and update of insurance coverage information.

Please remember the insurance is an agreement between you and your insurance company. Therefore, if any problem arises with the carrier, our office will provide your insurance company with any additional information necessary for resolution, but it will ultimately become the insurer's responsibility to handle any matters that occur.

I understand that if the insurance does not pay the full expected benefit, for any reason, I am responsible for all costs of the remaining balance.

____ ________________

Signature Date

Oral Surgery/ Anesthesiology Acknowledgement of Independent Contractor Status

This document is to advise you that your Oral Surgeon/ Anesthesiologist is not an employee or agent of this office. Your signature below acknowledges that you understand and agree that your Oral Surgeon/Anesthesiologist is an independent contractor. It further acknowledges that you understand that services received at any facility and that Abari Orthodontics/Oral Surgery will not be responsible for the actions of or the services provided by your Oral Surgeon/Anesthesiologist. All billing or other services performed on behalf of the Oral Surgeon/ Anesthesiologist are done as an accommodation.

Acknowledged and agreed.

____ ________________

Signature Date