ORAL SURGERY OFFICE, L.L.C.

____ David B. Coates, DDS

____ Jason A. DeWitt, DDS

Appointment Date: _____

Local/General/Consult _____

## Patient Information:

First Name:_____ Middle Initial:_____ Last:_____ Nickname:_____

Date of Birth: ___ /____/_____ Age: _____ Sex: ☐ Male ☐ Female Soc Sec. #_____

Address Street:_____City/State:_____ Zip: _____

Home Tel #: _____Work Tel #: _____Cell #: _____

Physician's Name:_____ Dentist's Name:_____

Who referred you to our office? ☐Dentist☐ Physician ☐Friend☐Other_____

Have you or any member of your family been a patient in our office before? ☐Yes ☐No When? (Year): ____

Who?: _____ Relationship to patient: _____

If patient is a full-time student, name of school: _____

Emergency Contact: _____ Daytime phone #: _____

Relationship to patient: _____

## Billing Information:

Responsible party for payment: First Name: _____ Last Name:_____

Date of Birth: ____/____/_____ Age: _____ Sex: ☐ Male ☐ Female Soc Sec#_____

Address Street:_____City/State:_____Zip: _____

Employer:_____ Work Tel#:_____

## DENTAL Insurance Coverage Information (If you have additional coverage, please request an additional form)

**Primary Dental Insurance**

Name of Insurance Company: _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____ Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

## MEDICAL Insurance Coverage Information (If you have additional coverage, please request an additional form)

**Primary Medical Insurance**

Name of Insurance Company: _____

Subscriber Name: _____ DOB: _____/_____/_____ Insured's Daytime Phone #: _____

Subscriber Address: _____ Plan ID (If other than SS#): _____

Subscriber Soc Sec #: _____ Group #: _____ Employer Name: _____

Relationship to Patient: _____ Insurance Co. Phone: _____

Insurance Co. Address: _____

# Medical History

Patient's Name: First:_____ Middle Initial:_____ Last:_____

Reason for today's office visit:_____ Height:_____
Weight:_____

| | Yes | No |
|---|---|---|
| Do you have **ALLERGIES** to anything either food, latex, and/or drugs? …… | □ | □ |

Please List _____

| | | |
|---|---|---|
| Have you ever had clicking or popping of your jaw joint, decreased jaw movement, or teeth grinding and clenching? ……..… | □ | □ |
| Have there been any changes in your general health in the past year? …… | □ | □ |
| Have you ever been hospitalized or undergone any surgery? ……. | □ | □ |

If yes to above,please explain:_____

**Do you have now or have you ever had any of the following conditions:**

| | Yes | No | Notes (for doctor) | | Yes | No | Notes (for doctor) |
|---|---|---|---|---|---|---|---|
| Heart Disease | | | | Anemia | | | |
| Chest Pain | | | | Bleeding Problems | | | |
| Heart Attack | | | | Sickle Cell Anemia | | | |
| Heart Bypass | | | | Stomach Ulcers | | | |
| Heart Catheterization | | | | Immune Disease | | | |
| Heart Murmur | | | | Immune Suppression | | | |
| Organ Transplant | | | | Cancer or Tumors | | | |
| Rheumatic Fever | | | | Radiation/Chemotherapy | | | |
| High Blood Pressure | | | | Liver Disease | | | |
| Artificial Heart Valve | | | | Hepatitis/Jaundice | | | |
| Pacemaker | | | | Diabetes | | | |
| Stroke | | | | Thyroid Disease | | | |
| Glaucoma | | | | Kidney Disease | | | |
| Asthma | | | | Arthritis | | | |
| Lung Disease | | | | Artificial Joints | | | |
| Tuberculosis | | | | Seizures (epilepsy) | | | |
| Shortness of Breath | | | | Alcohol/Drug Abuse | | | |
| Swollen Ankles | | | | Psychiatric Disorder | | | |
| Sleep Apnea/CPAP | | | | Mental Disability | | | |

Please list any drugs or medications you are currently taking including herbals and over the counter medications_____

_____

| | Yes | No |
|---|---|---|
| Have you ever had any adverse reactions to a local or general anesthetic? …… | □ | □ |
| Have you ever been prescribed any of the following medications?: (Please circle any) | | |
| Fosamax, Aredia, Zometa, Reclast, Actonel, Boniva, Xgeva, Prolia, Cortisone or Prednisone …… | □ | □ |
| Are you currently being prescribed pain medicines by another doctor? ……. | □ | □ |
| Is this visit the result of an accident? ……..… | □ | □ |
| If yes, please explain _____ | | |
| Do you smoke? …… | □ | □ _____ pack(s)/day |
| **Women:** | | |
| Are you pregnant? …… | □ | □ |
| Are you nursing? …… | □ | □ |
| Do you take birth control? * ……. | □ | □ |

**If an antibiotic is prescribed for you, and you are currently using a birth control pill, please be aware that the drug prescribed may interfere with the effectiveness of your birth control. The result could be an unplanned or unexpected pregnancy. Discuss other methods of birth control with your medical doctor.*

| | | |
|---|---|---|
| Is there any other condition concerning your health that the Doctor should know about? …… | □ | □ |

If so, please describe: _____

I certify that I have read and understand the above and that the information is correct and accurate. I will not hold my surgeon, or any other member of his staff responsible for any errors or omissions I have made in the completion of this form.

Signature of Patient : _____ Date: _____
*(Parent or Legal Guardian if minor)*

Reviewed by Dr. Coates □ Dr. DeWitt □ Date: