DESERT VALLEY ORAL SURGERY

Date:________________________

Patient Name:____ **Gender: ( ) M ( ) F Birth date :**________________________

Last First MI (Preferred Name)

Family Status : ( ) Married ( ) Single ( ) Child ( ) Other_________________ **Social Security#:**_______________________________

Address: ____ **City:**________________________ **State:**________ **Zip:**_____________

Phone (Home):________________________ **(Cell):**___________________________ **E-mail:**____

Who is financially responsible for this patient? (Name)________________________________ **(phone)** ______________________________

Who can we notify in case of emergency? (Name) ____________________________________ **(phone)**______________________________

If we are assisting in filing insurance on your behalf, please provide insurance card, photo ID, and information below.

Insured (subscriber) Name: _________________________ **Date of birth** ______________________ **ID #**______________________________

Name of Insurance ________________________________ **Group #**__________________________ **Employer**_________________________

Whom may we thank for referring you to our practice?

( ) Dental Office (name:____) ( ) Newspaper/Print ( ) Yellow Pages ( ) School ( ) Work

( ) Another patient, friend /relative (name:__________________________) ( ) Other ____

Reason for your visit today: ____

Have you ever had any of the following? Please check those that apply:

Y	N		Y	N		Y	N	
( )	( )	AIDS	( )	( )	Fainting	( )	( )	Nervous Disorders
( )	( )	Allergies	( )	( )	Glaucoma	( )	( )	Osteoporosis
( )	( )	Anemia	( )	( )	Grind or Clench Teeth	( )	( )	Pacemaker
( )	( )	Arthritis	( )	( )	Hay Fever	( )	( )	Radiation Treatment
( )	( )	Angina	( )	( )	Heart Valve	( )	( )	Respiratory Problems
( )	( )	Artificial Joints/implant	( )	( )	Heart Attack	( )	( )	Rheumatic Fever
( )	( )	Asthma	( )	( )	Heart Surgery	( )	( )	Rheumatism
( )	( )	Autism	( )	( )	Heart Disease	( )	( )	Seizures/Convulsions
( )	( )	Blood Disease	( )	( )	Heart Murmur	( )	( )	Sinus Problems
( )	( )	Blood Transfusion	( )	( )	Heart Palpitations	( )	( )	Stomach Problems
( )	( )	Cancer	( )	( )	Head Injuries	( )	( )	Stroke
( )	( )	Chronic Cough	( )	( )	High Blood Pressure	( )	( )	Thyroid Disease
( )	( )	Clicking/Popping Jaw	( )	( )	hepatitis	( )	( )	Tuberculosis
( )	( )	Dizziness	( )	( )	HIV	( )	( )	Tumors
( )	( )	Depressed Immune Sys	( )	( )	Kidney Disease	( )	( )	Ulcers
( )	( )	Diabetes	( )	( )	Liver Disease	( )	( )	Venereal Disease
( )	( )	Epilepsy	( )	( )	Lung Disease	( )	( )	Pregnant or any chance?
( )	( )	Emphysema	( )	( )	Mental Disorders			Due Date: ___________
( )	( )	Excessive Bleeding	( )	( )	Jaundice	( )	( )	Are you nursing?
( )	( )	Other: ______________________________						

Are you using any of the following? Please circle all that apply:

Antibiotics	Blood Thinners	Aspirin / Motrin, Aleve	Tranquilizers/ Muscle Relaxers	Heart Drugs
High Blood Pressure	Steroids/Cortisone	Digitalis/Phen Fen	Insulin/Anti-Diabetic Medication	Ibuprofen

Please list any other medications you are taking including prescription medications, diet drugs, over-the-counter medications, herbal for holistic remedies, vitamins or minerals:

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Have you ever used any of the following? Please check those that apply:
Bisphosphonates: Fosamax, Actonel, Boniva, Aredia, or Zometa (For Osteoporosis/Cancer). Phen-Fen

Are you allergic to or have you had an adverse reaction to any of the following? Please circle all that apply:

Local Anesthesia	Penicillin	Antibiotics	Sedatives	Barbiturates	Aspirin	Ibuprofen
Codeine	Pain Killers	Latex	Rubber	Sulfa	Eggs	Milk

OTHER:_________________________________

®Do you have any health problems that need further clarifications? ( ) Yes ( ) No
If yes, please explain: ____

®Have you ever had any complications following dental treatment? ( ) Yes ( ) No
If yes, please explain: ____

®Do you smoke or chew Tobacco products? ( ) Yes ( ) No If yes, how much per day: __________________

®Have you ever had past history of alcohol, chemical dependency or emotional disorders?
( ) Yes ( ) No If yes, please explain: ____

®Have you or an immediate family member ever had any problems associated with intravenous anesthesia? ( ) Yes ( ) No
If yes, please explain: ____

®Have you been admitted to a hospital or needed emergency care during the past two years?
( ) Yes ( ) No If yes, please explain: ____

®Name of Physician: ___________________________________ Phone: ___________________________________

®If you are using oral contraceptives, it is important to understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control.

®Do you wish to talk to the doctor privately about anything? ( ) Yes ( ) No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ ______________________
Signature of patient, parent or guardian Date

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Signature of Doctor