Ferneini
Maxillofacial
Surgical
Institute

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DIPLOMATE, AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY
FELLOW, AMERICAN COLLEGE OF SURGEONS

Health History

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

Please check any condition that you have currently or have been treated for in the past.

Cardiovascular (Heart)
- ○ High Blood Pressure
- ○ Heart Attack
- ○ Angina (Chest Pain)
- ○ Congestive Heart Failure
- ○ Irregular Heart Beat
- ○ Cardiac Pacemaker or Defibrillator
- ○ Heart Murmur
- ○ Mitral Valve Prolapse
- ○ Damaged Heart Valve
- ○ Heart Valve Replacement
- ○ Endocarditis
- ○ Congenital Heart Defect
- ○ High Cholesterol

Endocrine
- ○ Diabetes
- ○ Takes Insulin
- ○ Thyroid Disease
- ○ Hypoglycemia

Gastrointestinal
- ○ GERD (Acid Reflux)
- ○ Chron's Disease
- ○ Ulcers
- ○ Hiatal hernia
- ○ Hepatitis
- ○ Cirrhosis

Hematologic (Blood Disorders)
- ○ Anemia
- ○ Sickle cell anemia
- ○ Von Willebrands Disease / Hemophilia
- ○ Taking Blood Thinners (Coumadin, Plavix, Aspirin)

Immunologic
- ○ History of Cancer
- ○ ___Chemotherapy ___Radiation Therapy
- ○ HIV / AIDS
- ○ Lyme Disease
- ○ Lupus
- ○ Sjogrens Syndrome
- ○ Rheumatoid Arthritis

Musculoskeletal
- ○ Osteoporosis/Osteopenia
- ○ Do you take or have you ever taken bisphosphonates?
- ○ Joint Replacement
- ○ Fibromyalgia
- ○ Malignant Hyperthermia
- ○ TMJ / Facial Pain

Neurological/ Psychiatric
- ○ Migraine Headache
- ○ Stroke / TIA
- ○ Aneurysm
- ○ Seizures
- ○ Fainting / Dizzy Spells
- ○ Multiple Sclerosis
- ○ Dementia / Alzheimer's Disease
- ○ Autism
- ○ Bipolar
- ○ Depression / Anxiety

Renal (Urinary)
- ○ Renal Failure / Dialysis
- ○ Kidney Stones
- ○ Other: _____

Respiratory
- ○ Asthma
- ○ Chronic Bronchitis
- ○ Emphysema
- ○ Tuberculosis
- ○ Chronic Sinusitis
- ○ Seasonal Allergies
- ○ Sleep Apnea / Excessive Snoring

Vision
- ○ Glaucoma
- ○ Wear Contact Lenses

Women Only
- ○ Pregnant
- ○ Last Menstrual Period / /
- ○ Breast Feeding
- ○ Birth Control Pills

DO YOU SMOKE? Yes No

DO YOU USE ALCOHOL? Yes No

HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS?

DO YOU TAKE ANY MEDICATIONS? (PLEASE INCLUDE OVER THE COUNTER AS WELL AS PRESCRIPTIONS)

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act)

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Patient Signature _____ Date _____

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST POSSIBLE CARE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

_____ _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY DOCTORS INITIALS

Today's Date:_____ **PATIENT INFORMATION** F Cheshire

Mr. Mrs. Ms._____D.O.B._____Age_____
Address_____Home Phone_____
City_____Cell Phone_____
State_____ Zip _____ Work Phone_____
Employer_____Social Security #_____
Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Student Status: ☐ FT ☐ PT College_____City _____State_____

General Dentist_____ Physician_____
Referring Dentist (if different)_____

In case of Emergency, Please Contact: _____
Relation_____ Phone_____

PARENTS (pt **UNDER** the age of 18-please complete):Mother_____Father_____

RESPONSIBLE BILLING PARTY: (If different from pt. info. **UNDER** the age of 18 – parent present please complete)
Name_____ D.O.B._____
Address_____ Social Security #_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Employer_____Work Phone_____

SIGNATURE OF RESPONSIBLE BILLING PARTY_____

INSURANCE INFORMATION:
As an additional service to our patients, we will be happy to process your insurance claim. **FAILURE TO COMPLETE INSURANCE INFORMATION WILL RESULT IN THE TOTAL FEE BEING YOUR RESPONSIBILITY. THEREFORE WE NEED COMPLETE AND ACCURATE INFORMATION.**

Primary DENTAL Insurance Company_____
Primary Insured Party Name_____D.O.B._____
Primary Insured Party Address_____
Home Phone #_____Cell Phone #_____
Social Security #_____Patient's Relationship to Insured_____
Subscriber ID#_____Group ID#_____
Employer_____Work Phone_____

Primary MEDICAL Insurance Company_____
Primary Insured Party Name_____D.O.B_____
Primary Insured Party Address_____
Home Phone #_____Cell Phone #_____
Social Security #_____Patient's Relationship to Insured_____
Subscriber ID#_____Group ID#_____
Employer_____Work Phone _____