

PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

Michael E. Clarke, DDS, MS

ORAL AND MAXILLOFACIAL SURGERY

Title: (Mr., Mrs., Ms., Dr.) First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  Male  Female Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Tel.: (\_\_\_\_) \_\_\_\_\_ Bus. Tel.: (\_\_\_\_) \_\_\_\_\_ Ext.: \_\_\_\_\_

Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Referred by: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

Reason for Being Referred to Our Office: \_\_\_\_\_

Family Members Who Have Been Patients: \_\_\_\_\_

Occupations: (Parents of Minors) \_\_\_\_\_

Student: \_\_\_\_\_ School Name/Address: \_\_\_\_\_

INSURANCE COMPANY:

INSURED PARTY/RESPONSIBLE PARTY:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relation to Insured:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Street: \_\_\_\_\_

Does your plan cover:  Dental  Medical  Both City, State, Zip: \_\_\_\_\_

Group No.: \_\_\_\_\_ Group Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Local: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

EMPLOYER INFORMATION:

Name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you have additional insurance information please notify the Front Office.

FEES and PAYMENTS

We make very effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms but please complete the identifying information at the top of the form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid tot the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedure and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the named of the insurance benefits otherwise payable to me.

Signature: \_\_\_\_\_

# HEALTH HISTORY

English

Patient Name: \_\_\_\_\_ Patient Identification Number: \_\_\_\_\_

Birth date: \_\_\_\_\_

## I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1.  Yes  No Is your general health good?
2.  Yes  No Has there been a change in your health within the last year?
3.  Yes  No Have you been hospitalized or had a serious illness in the last three years?  
If YES, why? \_\_\_\_\_
4.  Yes  No Are you being treated by a physician now? For what? \_\_\_\_\_  
Date of last medical exam? \_\_\_\_\_ Date of last Dental exam \_\_\_\_\_
5.  Yes  No Have you had problems with prior dental treatment?
6.  Yes  No Are you in pain now?

## II. HAVE YOU EXPERIENCED:

- |  |  |  |                        |
|--|--|--|------------------------|
| 7. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Chest pain (angina)?                     | 18. <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness?             |
| 8. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Swollen ankles?                          | 19. <input type="checkbox"/> Yes <input type="checkbox"/> No | Ringing in ears?       |
| 9. <input type="checkbox"/> Yes <input type="checkbox"/> No  | Shortness of breath?                     | 20. <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches?             |
| 10. <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight loss, fever, night sweats? | 21. <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting spells?       |
| 11. <input type="checkbox"/> Yes <input type="checkbox"/> No | Persistent cough, coughing up blood?     | 22. <input type="checkbox"/> Yes <input type="checkbox"/> No | Blurred vision?        |
| 12. <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding problems, bruising easily?      | 23. <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures?              |
| 13. <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus problems?                          | 24. <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive thirst?      |
| 14. <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty swallowing?                   | 25. <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent urination?    |
| 15. <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea, constipation, blood in stools? | 26. <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry mouth?             |
| 16. <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent vomiting, nausea?               | 27. <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice?              |
| 17. <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty urinating, blood in urine?    | 28. <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint pain, stiffness? |

## III. DO YOU HAVE OR HAVE YOU HAD:

- |  |   |  |                             |
|--|---|--|-----------------------------|
| 29. <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart disease?                                      | 40. <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS                        |
| 30. <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart attack, heart defects?                        | 41. <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, cancer?             |
| 31. <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmurs?                                      | 42. <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis, rheumatism?      |
| 32. <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever?                                    | 43. <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye diseases?               |
| 33. <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke, hardening of arteries?                      | 44. <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin diseases?              |
| 34. <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure?                                | 45. <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia?                     |
| 35. <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma, TB, emphysema, other lung diseases?         | 46. <input type="checkbox"/> Yes <input type="checkbox"/> No | VD (syphilis or gonorrhea)? |
| 36. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis, other liver disease?                     | 47. <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes?                     |
| 37. <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach problems, ulcers?                           | 48. <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney, bladder disease?    |
| 38. <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies to: drugs, foods, medications, latex?     | 49. <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid, adrenal disease?   |
| 39. <input type="checkbox"/> Yes <input type="checkbox"/> No | Family history of diabetes, heart problems, tumors? | 50. <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes?                   |

## IV. DO YOU HAVE OR HAVE YOU HAD:

- |  |                         |  |                     |
|--|-------------------------|--|---------------------|
| 51. <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care?       | 56. <input type="checkbox"/> Yes <input type="checkbox"/> No | Hospitalization?    |
| 52. <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation treatments?   | 57. <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood transfusions? |
| 53. <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy?           | 58. <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgeries?          |
| 54. <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthetic heart valve? | 59. <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker?          |
| 55. <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial joint?       | 60. <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact lenses?     |

## V. ARE YOU TAKING:

- |  |  |  |                      |
|--|--|--|----------------------|
| 61. <input type="checkbox"/> Yes <input type="checkbox"/> No | Recreational drugs?  | 63. <input type="checkbox"/> Yes <input type="checkbox"/> No | Tobacco in any form? |
| 62. <input type="checkbox"/> Yes <input type="checkbox"/> No | Drugs, medications, over-the-counter medicines<br>(including Aspirin), natural remedies? | 64. <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol?             |

Please list: \_\_\_\_\_

## VI. WOMEN ONLY:

- |  |  |  |                             |
|--|--|--|-----------------------------|
| 65. <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you or could you be pregnant or nursing? | 66. <input type="checkbox"/> Yes <input type="checkbox"/> No | Taking birth control pills? |
|--|--|--|-----------------------------|

## VII. ALL PATIENTS:

67.  Yes  No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: \_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_