Vallejo Oral Surgery and Implantology

HEALTH HISTORY

Oral and Maxillofacial Surgeons treat primarily the mouth, jaws and related facial structures, but any health problems, medicines or drugs affect the treatment you receive. Because of our concern for you, we are obligated to ask the following questions. Please answer them as completely and as accurately as possible. Your answers will help guide our decisions on which treatment is best for you. Thank You.

PATIENT'S NAME: _____ _____ _____ DATE OF BIRTH _____ AGE _____ SEX: M ☐ F ☐
LAST FIRST MI

HEIGHT _____ WEIGHT _____

If you are completing this form for another person, what is your name and relationship? _____

1. What is your "Chief Complaint" (What is your problem)? _____

Also, is your visit related to any of the following?

a. wisdom teeth ☐
b. bad teeth ☐
c. jaw or tooth pain ☐
d. infection/swelling ☐
e. loose teeth ☐
f. bad breath ☐
g. teeth sensitive to cold, heat, sweets or pressure ☐
h. facial trauma (hit in face, broken jaw, etc.) ☐
i. facial pain or headaches ☐
j. growth in mouth ☐
k. a bad bite ☐
l. over-bite ☐
m. jaw joint (TMJ) ☐
n. implants ☐

2. Is condition related to the patient's employment..... ☐ ☐
3. Is condition related to an accident?..... ☐ ☐
   Give date: ____ / ____ / ____
4. Have you had previous consultation or treatment of the present problem?..... ☐ ☐
   With whom? _____
5. Address, phone of the person who sent you to us, if known:
   _____
   _____
   _____
6. Present health (circle one)
   a. Physical..... Good ☐ Fair ☐ Poor ☐
   b. Emotional..... Good ☐ Fair ☐ Poor ☐
7. Has there been any change in your health in the past year?..... ☐ ☐
8. Have you been under care of a physician during the past two years?..... ☐ ☐
   a. What condition? _____
9. Date of your last physical exam by a physician:
   ____ / ____ / 20____
10. Name and address of your physician:
    _____
    _____
    _____ _____
11. Have you ever been hospitalized?..... ☐ ☐

Reason for Hospitalization	*Hospital*	*Year*

12. Do you have, or have you had, any of the following diseases or problems?
    a. Glaucoma..... ☐ ☐
    b. Rheumatic fever or rheumatic heart disease..... ☐ ☐
    c. Heart murmur or mitral valve prolapse..... ☐ ☐
    d. Congenital heart disease..... ☐ ☐
    e. Heart surgery..... ☐ ☐
    f. Cardiovascular disease (heart trouble, heart attack attack, coronary insufficiency, coronary occlusion high blood pressure, low blood pressure atherosclerosis, stroke)..... ☐ ☐
    g. Do you get very short of breath after climbing one flight of stairs?..... ☐ ☐
    h. Do you get short of breath upon laying down?..... ☐ ☐
    i. Do your ankles swell during the day..... ☐ ☐
    j. Do you ever feel that your heart is beating too fast or irregularly?..... ☐ ☐
    k. Have you ever had fainting spell?..... [Y] [N]
    l. Do you ever get pains in your chest over your heart?..... ☐ ☐
    m. Do you have a cardiac pacemaker?..... ☐ ☐
    n. Allergy..... ☐ ☐
    o. Sinus trouble or hay fever..... ☐ ☐
       have you been told you have nasal polyps?.. ..... ☐ ☐
    p. Respiratory problems, emphysema, bronchitis..... ☐ ☐
    q. Asthma..... ☐ ☐
       has asthma attack required emergency care?..... ☐ ☐
    r. Tuberculosis or other lung infection..... ☐ ☐
    s. A persistent cough or cough up blood..... ☐ ☐
    t. Hives or skin rash..... ☐ ☐
    u. Fainting, epilepsy, seizures..... ☐ ☐
    v. Nervousness or depression..... ☐ ☐
    w. Psychiatric problems..... ☐ ☐
    x. Thyroid trouble..... ☐ ☐
    y. Addison's disease..... ☐ ☐
    z. Diabetes (blood sugar)..... ☐ ☐
       How long? ____ Your last blood sugar? ____ mg/dl
       Your last Hb A1c ____ % When was it done? _____
       1) Do you urinate more than six (6) times a day ..... ☐ ☐
       2) Are you thirsty most of the time?..... ☐ ☐
       3) Does your mouth become frequently become dry?..... ☐ ☐
    aa. Hepatitis, jaundice or liver disease..... ☐ ☐
    bb. Gall bladder disease..... ☐ ☐
    cc. Stomach trouble..... ☐ ☐
    dd. Stomach ulcers..... ☐ ☐
    ee. Arthritis or rheumatism (painful swollen joints)..... ☐ ☐
    ff. Artificial joint replacement..... ☐ ☐
    gg. Kidney trouble..... ☐ ☐
    hh. Anemia (low blood)..... ☐ ☐
    ii. Sickle cell anemia..... ☐ ☐
    jj. Hemophilia..... ☐ ☐
    kk. Venereal disease-STD (syphilis, gonorrhea)..... ☐ ☐
    ll. HIV or AIDS ..... ☐ ☐
    mm. Chills or fever..... ☐ ☐
    nn. Recent unwanted weight loss..... ☐ ☐
13. Do you have an immune system condition?..... ☐ ☐
    a. Frequent cold sores or herpes infections?..... ☐ ☐
    b. Thrush infection in the mouth?..... ☐ ☐
    c. Persistent swollen glands in the neck?..... ☐ ☐
    d. Persistent diarrhea or recent weight loss?..... ☐ ☐
14. Have you had a tumor or cancer? ..... ☐ ☐
    a. Or x-ray treatment in the head or neck area for tumor or cancer?..... ☐ ☐
15. Have you experienced prolonged bleeding following a tooth extraction, a cut, surgery or or injury?..... ☐ ☐
    a. Bruise easily?..... ☐ ☐
    b. Ever had blood transfusion?..... ☐ ☐
    c. Do you have frequent nose bleeds?..... ☐ ☐
16. Do you snore heavily after falling asleep?..... ☐ ☐
    a. Have you been told you stop breathing while asleep? ☐ ☐
    b. Do you fall asleep at inappropriate times, i.e. driving? ☐ ☐

17. Do you have headaches?..... ☐ ☐
    a. What area of your head aches?
       ☐ side ☐ front ☐ top ☐ back
    b. How often do you have them?
       ☐ daily ☐ weekly ☐ monthly ☐ seldom
    c. Are headaches? ☐ throbbing ☐ continuous ache
       ☐ sharp ☐ dull
18. Does your jaw click or pop when you chew?..... ☐ ☐
    a. Has your jaw ever click or popped when chewing?..... ☐ ☐
    b. Has your jaw ever hurt on opening wide?..... ☐ ☐
18. Does your jaw hurt when you chew?..... ☐ ☐
    a. Has your jaw ever hurt when chewing?..... ☐ ☐
    Where? ☐ In front of ear ☐ side of head ☐ side of jaw
20. *Any other problem we should know about?*..... ☐ ☐
    What?_____
21. Have you ever taken diet pills (Fen-Phen, Redux, etc)?..... ☐ ☐
22. Are you taking any medicine now?..... ☐ ☐
23. Is there any medicine you should be taking now.. ☐ ☐
24. If yes, which:
    a. Antibiotics..... ☐ ☐
    b. Sulfa drugs..... ☐ ☐
    c. Anticoagulants (blood thinners)..... ☐ ☐
    d. High blood pressure medicine..... ☐ ☐
    e. Cortisone (steroids)..... ☐ ☐
    f. Tranquilizers..... ☐ ☐
    g. Antihistamines..... ☐ ☐
    h. Aspirin..... ☐ ☐
    i. Aspirin substitutes..... ☐ ☐
    j. Insulin (medicine for Diabetes)..... ☐ ☐
    k. Digitalis or drugs for heart trouble..... ☐ ☐
    l. Nitroglycerine (medicine for chest pain..... ☐ ☐
    m. Dilantin (medicine for seizures)..... ☐ ☐
    n. Antidepressants..... ☐ ☐
    o. Oral contraceptives (birth control pills)..... ☐ ☐
    p. Hormones..... ☐ ☐
    q. Bisphosphonates (Fosamax, Actonel) drugs to treat osteoporosis..... ☐ ☐
    r. Medical marijuana..... ☐ ☐
    s. Erectile dysfunction (Viagra, Cialis)..... ☐ ☐
    t. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:

25. Are you allergic to or have you reacted badly to?
    a. Local anesthetics (dental injections, spinal anesthesia)..... ☐ ☐
    b. Penicillin..... ☐ ☐
    c. Clindamycin (Cleocin) ..... ☐ ☐
    d Sulfa drugs..... ☐ ☐
    e. Other antibiotics..... ☐ ☐

25. Cont'd) Are you allergic to or have you reacted badly to?
    f. Barbiturates..... ☐ ☐
    g. Sedatives or sleeping pills..... ☐ ☐
    h. Aspirin..... ☐ ☐
    i. Aspirin substitutes like Tylenol®..... ☐ ☐
    j. Ibuprofen like Motrin® or Advil®..... ☐ ☐
    k. Iodine..... ☐ ☐
    l. Codeine..... ☐ ☐
    m. Other narcotics..... ☐ ☐
    n. Latex..... ☐ ☐
    o. Eggs, soy bean..... ☐ ☐
    p. Other foods..... ☐ ☐
    q. Other allergens:_____
26. Marital Status: Select . . .
27. Do you smoke or use tobacco in any form?..... ☐ ☐
    What?_____
    How much?_____ How long?_____
28. Have you used heroin, cocaine, marijuana or other such drugs?..... ☐ ☐
29. Do you drink alcoholic beverages?..... ☐ ☐
    What?_____
    How much?_____ How long?_____
30. Date last dental check-up? ____/____/20____
31. Date last dental cleaning? ____/____/20____
32. Have you worn the same denture/partial more than 5 yrs.?..... ☐ ☐
33. Has patient or anyone in the family ever had problem with being put to sleep or being sedated for a medical or dental procedure?..... ☐ ☐
    Explain:_____
34. Father - Age____ Diseases_____ [Deceased] ☐
    Mother - Age____ Diseases_____ [Deceased] ☐
35. Is there a history of oral cancer in your family..... ☐ ☐
    a. Other cancers ..... ☐ ☐
36. Do you wear contact lenses?..... ☐ ☐
37. Are you wearing a removable dental appliance?..... ☐ ☐
38. Do you have a cold or sore throat?..... ☐ ☐
39. Have you had anything to eat or drink in the last 6 hours?..... ☐ ☐
40. Is there anything you would like to discuss in private with the doctor?..... ☐ ☐
41. **How do you feel about coming to us about your problem?**

☺ NO PROBLEM ☐ 😐 APPREHENSIVE ☐ ☹ SCARED ☐

FOR WOMEN ONLY

42. Are you or do you think you may be pregnant?..... ☐ ☐
43. Are you nursing a baby?..... ☐ ☐
44. Do you have problems associated with your menstrual period?..... ☐ ☐
    Date of your last period ____/____/____

NOTES:

YOUR PRIMARY DENTIST'S NAME:_____ PHONE NUMBER: (___) _____

YOUR PRIMARY PHYSICIAN'S NAME:_____ PHONE NUMBER: (___) _____

I CERTIFY THAT ALL RESPONSES HEREIN GIVEN ARE TRUE AND CORRECT ABOUT MYSELF OR THE PATIENT BECAUSE, I UNDERSTAND THAT MY RESPONSES ASSIST IN DIAGNOSING AND PREPARING TO TREAT MY PROBLEM(S)

SIGNATURE OF PATIENT DATE

REVIEWED BY (for office use only) DATE

SIGNATURE OF OTHER (RELATIONSHIP) DATE

REVIEWED BY (for office use only) DATE

Established 1918

Vallejo Oral Surgery and Implantology
Oral and Maxillofacial Surgery
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent
Name/please PRINT: _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:
Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, or the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of the protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions, at any time by contacting the office.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

SIGNATURE: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use of my disclosure of my protected health information to carry our treatment payment activities and health care operations.

SIGNATURE_____**. Date**_____

If this Consent is signed by a personal representative, on behalf of the patient, complete the following:
Personal Representative Name: _____
Relationship to Patient: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement ***

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgments could not be obtained because (circle one):

1. Individual refused to sign
2. Communications barriers prohibited obtaining the acknowledgment
3. An emergency situation prevented us from obtaining the acknowledgment
4. Other (please specify)_____

PAYMENT POLICY

Insurance Patients: Due to the overwhelming number of insurance companies and their different policies, it is impossible for us to give you a true estimate of the proposed insurance reimbursement. In order to bill your insurance company, we must have have your insurance information, including the mailing address and your ID number. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing the benefits of your individual plan. We require a minimum payment of 50%, unless you are a Delta Dental member, to be made at the time services are rendered. If this is not acceptable, we are willing to pre-authorize the proposed treatment in writing, which usually delays surgery for 6-8 weeks. It is your responsibility to pay for services not covered by your insurance company.

Non-Insurance Patients: Payment in full is expected at the time of service unless other financial arrangements have been made.

PATIENT OR RESPONSIBLE PARTY SIGNATURE_____**. Date**_____