KELOWNA ORAL & FACIAL SURGERY

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V1Y 0G1

Today's Date 10/12/2019

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ (DD/MM/YYYY) Age _____ E-mail _____

Street _____ Apt. _____ City _____ Province _____ Postal Code _____

Best Contact Tel. (_____) _____ Other Contact Tel. (_____) _____

Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ Orthodontist _____

Medical Dr. _____ (FIRST NAME) _____ (LAST NAME) Preferred Pharmacy _____ Tel.(_____) _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) E-mail _____

Best Contact Tel. (_____) _____ Other Contact Tel. (_____) _____

PRIMARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # / Cert. # _____

Group # / Contract _____

Policy Holder _____ (FIRST NAME) _____ (LAST NAME)

Policy Holder's Birth Date _____ (DD/MM/YYYY)

SECONDARY DENTAL INSURANCE COMPANY:

Ins. Co. Name _____

I.D. # / Cert. # _____

Group # / Contract _____

Policy Holder _____ (FIRST NAME) _____ (LAST NAME)

Policy Holder's Birth Date _____ (DD/MM/YYYY)

CANADIAN MEDICAL INSURANCE:

Province _____ Health Care # _____

HEALTH HISTORY:

To our patients: *Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.*

Reason for today's office visit?

		Yes	No
1.	***Height*** _____ ***Weight*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, operation or been hospitalized in the past five years?	❑	❑
	If so, describe _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you ever had general anesthesia?	❑	❑
9.	Have you, or a family member, had any unusual or serious reactions to general anesthesia?	❑	❑
10.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
11. Rheumatic fever?			
12. Damaged heart valves / mitral valve prolapse?			
13. Heart murmur?			
14. High blood pressure?			
15. Low blood pressure?			
16. Chest pain / angina?			
17. Heart attack(s)?			
18. Irregular heart beat?			
19. Cardiac pacemaker?			
20. Heart surgery?			
21. Pneumonia, bronchitis, chronic cough?			
22. Asthma?			
23. Hay fever / sinus problems?			
24. Snoring?			
25. Sleep apnea / CPAP?			
26. Difficult breathing / other lung trouble?			
27. Tuberculosis?			
28. Emphysema?			
29. Do you smoke or vape? If so, how much a day_____			
30. Do you use chewing tobacco?			
31. Blood transfusion?			
32. Blood disorder such as anemia?			
33. Bruise easily?			
34. Bleeding tendency / abnormal bleed?			
35. Hepatitis, jaundice, or liver disease?			
36. Infectious mononucleosis?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
37. Gallbladder trouble?			
38. Fainting spells?			
39. Convulsions / epilepsy?			
40. Stroke?			
41. Thyroid trouble?			
42. Diabetes?			
43. Low blood sugar?			
44. Kidney trouble?			
45. High cholesterol?			
46. Are you on dialysis?			
47. Swollen ankles / arthritis / joint disease?			
48. Osteoporosis / osteopenia?			
49. Osteonecrosis?			
50. Stomach / acid reflux?			
51. Contagious diseases?			
52. Sexually transmitted diseases?			
53. Problems with immune system? Possibly from medication / surgery, etc.			
54. Delay in healing?			
55. A tumor or growth?			
56. Cancer / radiation therapy / chemotherapy?			
57. Chronic fatigue / night sweats?			
58. Are you on a diet?			
59. A history of alcohol abuse?			
60. A history of marijuana or other drug use?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			

WOMEN ONLY: *(QUESTIONS 64–67)*

	Yes	No
64. Is there a possibility of pregnancy?	❑	❑
65. Expected delivery date?_____		
66. Are you nursing?	❑	❑
67. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

ARE YOU NOW TAKING:	YES	NO	NOTES
68. Any kind of medication, drug, pills?			
69. Blood thinners?			
70. Have you ever taken diet pills?			
71. Any natural product, herbal supplement or homeopathic remedy?			
72. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates in the past 12 years?			

73. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

74. If you are under the care of a physician for pain management, or recovering from drug addiction please select the medication you are currently taking: ❑ Methadone ❑ Suboxone ❑ Oxycodone ❑ Fentanyl ❑ Other_____

Treating doctor:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:		
Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
75. Local anesthetic (freezing)?			
76. Penicillin / amoxicillin?			
77. Sulfa drugs?			
78. Clindamycin?			
79. Aspirin / ibuprofen?			
80. Other antibiotics?			
81. Codeine or other narcotics?			
82. Latex?			

83. Please list any other allergies:

If you are having surgery **today**, have you had anything to eat or drink in the last 6 (six) hours? ❑ Yes ❑ No

Who is driving you home? _____

Is there any condition concerning your health that the Doctor should be told about? ❑ Yes ❑ No – If Yes, describe

_____

Do you wish to speak to the Dr. privately about anything? ❑ Yes ❑ No

Is there a family history of:

❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

Is this visit related to an accident? ❑ Yes ❑ No

If Yes, what type of accident? ❑ Automobile ❑ Work related ❑ Other

Date of injury _____

Insurance company handling the claim _____

Claim number _____

Name of attorney / adjustor _____

Telephone number (_____) _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date** **Witness** **Date**

FEES & PAYMENTS

Payment is due in full at the time treatment is rendered. An estimate of the costs for any procedure or surgery you may require will be provided to you. If you have dental insurance we will be glad to fill out the claim forms on your behalf, and you will be reimbursed directly according to your insurance plan.

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim.

X _____ **X** _____

Signature of patient: *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile device concerning my care.

X _____ **X** _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Doctor** **Date**