ORAL MAXILLOFACIAL SURGERY

PROVINCIAL ORAL SURGERY
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Please Complete Information In Full

Full Name: _____
Last *First* *M.I.*

Name of Parent or Guardian: _____
If Patient is under 18 years of age

Age: _____ **DOB:** ___/___/___ **Gender:** M F X **Marital Status:** _____ **Height:** _____ **Weight:** _____
Month/Day/Year

Address: _____
Street *Apt/Unit* *City* *Province* *Postal Code*

Phone: _____ **Email:** _____
Cell *Home* *Alternate*

Health Card #: _____ Supplemental Health / Indian Affairs / Canadian Dental Care Plan: Y or N #: _____

Physician's Name: _____ Dentist's Name: _____

Private Insurance? Y / N Private Insurance Name: _____

Subscriber ID/Member ID#: _____ Group Policy#: _____

Employees Name: _____ Employees DOB: ___/___/___ Relationship to you: _____
Month / Day / Year

Health History

Last Physical Exam: _____ Last Surgery: _____ Last Hospitalization: _____

Are you in good health? Y / N Are you taking any medications>: Y / N List: _____
(Prescription, Non-Prescription, Herbal Medicine, list on back of page if more space needed)

Preferred Pharmacy?: _____

History / Family History of General Anesthesia Problems: Y / N - If so explain: _____

Are you allergic to/have a reaction to any medications (lidocaine, penicillin, aspirin, etc)? _____

Other Allergies (latex, etc)? _____

If yes to Allergies, please explain the type of allergic reaction: _____

DO YOU USE or HAVE YOU EVER USED:

Tobacco? Y/N Type: Years: Frequency: Alcohol: Drinks/week:

Marijuana? Y/N Type: Years: Frequency:

Illegal Drugs? Y/N Type: Years: Frequency:

WOMEN ONLY:

Are you pregnant?: Y / N Are you trying to get pregnant?: Y / N Menstrual Problems?: Y / N Birth Control Pills?: Y / N Breastfeeding?: Y / N

DO YOU HAVE ANY OF THE FOLLOWING *(circle, explain below)*

Heart Trouble	Respiratory Problems	Thyroid Problems	Fainting Spells	Hepatitis (A, B, C)
Damaged Heart Valve	Asthma	Osteoporosis	Seizures	HIV / AIDS
Artificial Valve	COPD	Kidney Trouble	Stroke	Sexually Transmitted Disease
Heart Murmur	Persistent Cough	Liver Problems	Epilepsy	Ulcer
Heart Attack	Tuberculosis	Transplant Type?	Anxiety/ Depression	Mouth Sores
Rheumatic Heart Disease	Sinus Trouble	Jaundice	Cancer	Swollen Glands
High Blood Pressure	Type I Diabetes	Abnormal Bleeding	Chemotherapy	Hay Fever
Low Blood Pressure	Type II Diabetes	Blood Transfusions	Radiation Therapy	OTHER:

Explain: _____

_____

Reason for referral to our office: _____ **Referred by:** _____

Disclaimer and Signature

I have read and understand all the above and have filled out the above information to the best of my knowledge.

Signature: _____ **Date:** _____
Patient Signature / Under 18 years of age Parent/Guardian Signature