North Atlanta Oral and Maxillofacial Surgery **HEALTH HISTORY**

PATIENT'S NAME_____**DOB:**_____ **DATE** _____

1. **Family Physician** Name _____Phone_____
   Address _____
2. **Pharmacy** Name _____Phone_____
   Address _____
3. **Specialist** Name _____Phone_____
   Address _____
4. **Family Dentist** Name _____Phone_____
   Address _____

5. Have you taken any medicine or drugs during the past two years? CIRCLE: yes / no

6. Are you now taking any medications, drugs, or pills? **This includes any bone building drugs (Bisphosphonates) such as Actonel, Boniva, Fosamax, Zometa, etc.** If so, please list medicine and dosage –**please include Herbal Meds/Supplements**:_____

7. Are you allergic or have you reacted adversely to any of the following medications? CIRCLE:

☐ Aspirin	☐ Nitrous Oxide	☐ Local Anesthetic
☐ Valium	☐ Scopolamine	(Novocaine or Xylocaine)
☐ Darvon	☐ Erythromycin	☐ Sleeping Pills
☐ Codeine	☐ Tetracycline	(Nembutal or Seconal)
☐ Demerol	☐ Penicillin	☐ Ibuprofen
☐ Percodan	☐ Other Antibiotics	☐ Latex

Are you aware of being allergic to any other medication or substance? CIRCLE: yes / no
If so, please list: _____

8. **Height:** _____ **Weight:** _____ Regular Exercise/Sport: _____
   Alcohol: _____ Tobacco: _____ Snoring/Sleep Apnea: _____
   Date of last physical: _____/_____/_____

9. Check all of the following boxes that <u>you/patient</u>, have had or have at the present.

NOTE: It is imperative that all conditions, diagnoses, diseases are disclosed

☐ Heart Failure	☐ Emphysema	**Other Conditions Diagnosed/Date**
☐ Heart Disease or Attack	☐ Cough	1._____
☐ Angina Pectoris	☐ Tuberculosis	_____
☐ High Blood Pressure	☐ Asthma or Shortness of Breath	Additional Info: _____
☐ Heart Murmur	☐ Hay Fever	_____
☐ Rheumatic Fever	☐ Sinus Trouble	_____
☐ Congenital Heart Lesions	☐ Allergies or Hives	2._____
☐ Scarlet Fever	☐ Diabetes	_____
☐ Artificial Heart Valve	☐ Thyroid Disease	Additional Info: _____
☐ Heart Pacemaker	☐ X-ray or Cobalt Treatment	_____
☐ Heart Surgery	☐ Chemotherapy(Cancer, Leukemia)	_____
☐ Artificial Joints (Knee, Hip)	☐ Arthritis	3._____
☐ Anemia	☐ Rheumatism	_____
☐ Stroke	☐ Cortisone Medication	Additional Info: _____
☐ Kidney Trouble	☐ Glaucoma	_____
☐ Ulcers	☐ Pain in Jaw Joints	_____
☐ Cosmetic Surgery	☐ Cold Sores	4._____
☐ Sickle Cell Disease	☐ Fever Blisters	_____
☐ Hepatitis A (Infectious)	☐ Hepatitis B (Serum)	Additional Info:_____
☐ Liver Disease	☐ Yellow Jaundice	_____
☐ Blood Transfusion	☐ Drug Addiction	_____
☐ Hemophilia	☐ Venereal Disease (Syphilis, Gonorrhea)	5._____
☐ Epilepsy or Seizures	☐ Herpes	_____
☐ Fainting or Dizzy Spells	☐ Nervousness	Additional Info: _____
☐ ADD	☐ Bruise Easily	_____
☐ ADHD	☐ Psychiatric Treatment	_____
☐ Asperger's syndrome	☐ Autism	_____
		Special Needs:_____

IT IS IMPERATIVE THAT THE SECTIONS BELOW ARE COMPLETED

DETAILED AND ACCURATE PATIENT AND FAMILY MEDICAL HEALTH HISTORY IS CRITICAL

Are you immune suppressed? _____ yes _____ no
Have you ever-required long-term antibiotic therapy? _____ yes _____ no
Do you have frequent oral sores? _____ yes _____ no
Do you require steroid medications in conjunction with medical treatment? _____ yes _____ no

10. **Have you, the patient, ever been admitted to the hospital for any reason?** (i.e. broken bones, childbirth, etc.)
List reason and date:

_____
_____

11. **Have you, the patient, ever had surgery of any kind?** (i.e. appendectomy, previous oral surgery) Have you had any problems with a previous general anesthesia? (i.e. post operative nausea/vomiting, reaction to medication)
List procedure and date:

_____
_____

12. In your **family medical history** (mother's or father's side of the family - up to the patient's grandparents) is there a history of major illness/disease? (i.e. heart attack or heart disease, high blood pressure, stroke, cancer, diabetes, etc.) List family member and illness/disease:

_____
_____

13. FOR WOMEN ONLY:

Are you pregnant? _____ yes _____ no Due date? _____
Are you nursing? _____ yes _____ no
Are you taking birth control pills? _____ yes _____ no

THE ABOVE INFORMATION IS TRUE.

Patient/Guardian Signature:_____

CONSENT:
The undersigned hereby authorizes a provider of North Atlanta Oral and Maxillofacial Surgery to order/take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the provider to make a thorough diagnosis of the patient's oral and maxillofacial needs.

I understand that payment for my services provided in this office for my dependent or myself is mine is due at the time the services are rendered unless financial arrangements have been made. I further understand that any outstanding balances not paid within 90 days of the first statement are subject to additional fees due to any additional efforts that have to be taken by an outside collection agency.

I hereby authorize payment from my insurance company, directly to ***North Atlanta Oral and Maxillofacial Surgery***.

I also authorize release of any information related to this claim.

_____
(Signature of Patient, Parent, Guardian, or Responsible Party)

_____
(Please print name of Patient, Parent, Guardian or Responsible Party)

_____ _____
Date Relationship to Patient