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 (Nembutal/Seconal)
Codeine	Tetracycline	Ibuprofen
Demerol	Penicillin	Amoxicillin
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. **Circle** any of the following that you, the patient, 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. **HEART:**_____
Epilepsy or Seizures	Herpes	_____
Fainting or Dizzy Spells	Nervousness	Additional Info: _____
ADD	Bruise Easily	_____
ADHD	Psychiatric Treatment	**LUNGS:**_____
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