IcuSmile Specialty Clinic

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PATIENT INFORMATION ONLY

Patient ______________________ Date of Birth ______________ Age ________

Address ____
STREET TOWN STATE ZIP

Mailing address if different ____

E-Mail Address ____

Home Phone# ______________ Work Phone# ______________ Cell Phone# ______________

SS# ______________ Marital Status: ❏ Single ❏ Married ❏ Minor Sex: ❏ Male ❏ Female

Patient Employer ______________________ Occupation ______________________

Address ____

Are you a college student? School ______________ Address ______________________

In case of emergency contact ______________ Relationship ______________ Phone# ______________

Family Dentist ______________________ Phone# ______________________

Who may we thank for referring you?______________ **I will be paying today by: ❏ Cash ❏ Check ❏ Credit Card**

IF DIFFERENT THAN PATIENT

Name of person financially responsible ______________________ Date of Birth ______________

Address ____
STREET TOWN STATE ZIP

Home Phone# ______________ Work Phone# ______________ Cell Phone# ______________

Employer______________________ Address ______________________

SS# ______________________ Relationship to you ______________________

Release: I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment to other treating doctors. I understand that I am responsible for all costs of dental treatment. • I attest to the accuracy of the information on this page.

PATIENT OR LEGAL GUARDIAN SIGNATURE ______________________________ DATE ______________

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*** ________ ***Age*** ________ 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? If so, number of packs 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?			
37. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
38. Fainting spells or dizziness?			
39. Convulsions / epilepsy?			
40. Stroke / TIA?			
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 drug abuse?			
61. Contact lenses?			
62. Eye disease / glaucoma?			
63. Mental health problems / anxiety / depression?			
64. A removable dental appliance?			
65. Pain or clicking of jaws when eating?			

WOMEN ONLY: *(QUESTIONS 66–69)*

	Yes	No
66. Is there a possibility of pregnancy?	❑	❑
67. Expected delivery date?________________		
68. Are you nursing?	❑	❑
69. 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
70. Any kind of medication, drug, pills?			
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Eloquis, Fish oil)?			
72. Have you ever taken diet pills?			
73. Any natural product, herbal supplement or homeopathic remedy?			
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			

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

76. List any medications you are currently taking (including antibiotics):

Medication	Dosage	Frequency

Pharmacy name ________________

Tel. (_____) ________________

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

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
77. Local anesthetic (numbing meds.)?			
78. Penicillin?			
79. Other antibiotics?			
80. Sulfa drugs?			
81. Sodium pentothal / Valium /other tranquilizers?			
82. Aspirin?			
83. Amoxicillin?			
84. Codeine or other narcotics?			
85. Latex?			
86. Soy?			
87. Eggs / yolk?			
88. Sulfites?			
89. Do you have any known allergies?			

90. Please list any allergies other than drug allergies:

91. Please list any other medication or antibiotic you are allergic to:

Medication / Antibiotic Name

Medical Doctors:

Primary Care Name: ________________

Tel. (_____) ________________

Oncologist Name:________________

Tel. (_____) ________________

Cardiologist Name:________________

Tel. (_____) ________________

Endocronologist Name: ________________

Tel. (_____) ________________

Other Specialist Name: ________________

Tel. (_____) ________________

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 (______)________________

PATIENT DISCLOSURE INSTRUCTIONS

I wish to be contacted in the following manner (check all that apply):

- ❑ Text (______) ____________________
- ❑ E-Mail ____
- ❑ Cell Phone
- ❑ Home Phone
- ❑ Work Phone
- ❑ OK to leave a detailed message
- ❑ Leave a call back number only
- ❑ OK to confirm appointment

I allow you to give my clinical information to, or answer questions from (check all that apply):

- ❑ Spouse
- ❑ Parent
- ❑ Child
- ❑ None
- ❑ Other (specify) ____

I allow you to give my financial information to, or answer questions from (check all that apply):

- ❑ Spouse
- ❑ Parent
- ❑ Child
- ❑ None
- ❑ Other (specify) ____

I want Myra Brennan DMD to e-mail my estimate via:

- ❑ Encrypted e-mail
- ❑ Non-encrypted e-mail *(with the understanding that non-encrypted can be viewed by someone other than the intended recipient)*

X ____ **X** ________________

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

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** **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

X ____ **X** ________________

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

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ____ **X** ________________

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

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