

Columbus Oral and Maxillofacial Surgery, P.C.

www.ColumbusOMS.com

(Please complete in full – ink pen only)

PATIENT's Legal Name _____ (first) _____ (middle) _____ (last) Nickname _____
Address _____ (no. & street) _____ (city) _____ (state) _____ (zip)
Marital status: Single Married Widowed Divorced Separated
Birth date _____ Age _____ Sex _____ SSN _____
If Student: Full-time Part-time School _____
Employer _____ Occupation _____
Home # _____ Cell # _____ Work # _____ Email _____

PHYSICIANS (Full names please)

Referred by: _____ Phone # _____
General Dentist _____ Phone # _____
Orthodontist _____ Phone # _____
Family Physician _____ Phone # _____

SPOUSE PARENT or GUARDIAN Name _____
Address (if different) _____ (no. & street) _____ (city) _____ (state) _____ (zip)
Birth date _____ Marital Status _____ SSN _____
Employer _____ Occupation _____
Home # _____ Cell # _____ Work # _____ Email _____

PERSON RESPONSIBLE FOR ACCOUNT Self Spouse Parent Other (specify) _____
Name (if not already given) _____ Birth date _____ SSN _____
Address (if different) _____ (no. & street) _____ (city) _____ (state) _____ (zip)
Employer _____ Occupation _____
Home # _____ Cell # _____ Work # _____ Email _____

EMERGENCY CONTACT – Contact friend/relative (NOT LIVING WITH YOU)

Name _____ Relation to Patient _____
Home # _____ Cell # _____ Work # _____ Email _____

DENTAL INSURANCE (IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. _____ Phone # _____
Insurance Address _____
Insured's Name _____ Birth date _____ Relation to Patient _____
SSN _____ Policy/Certificate # _____
Employer's Group Name _____ Group # _____
Do you have secondary dental/medical? If so, please inform.

MEDICAL INSURANCE (IN ORDER TO FILE INSURANCE, PLEASE PROVIDE INSURANCE CARD & COMPLETE THIS SECTION)

Insurance Co. _____ Phone # _____
Insurance Address _____
Insured's Name _____ Birth date _____ Relation to Patient _____
SSN _____ Policy/Certificate # _____
Employer's Group Name _____ Group # _____

AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED.

I authorize the doctor and other dentists or health-care professionals (interdisciplinary team members) to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize the taking of photographs, radiographs and other diagnostic records before, during, and after treatment and to use the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature. I authorize **Columbus Oral & Maxillofacial Surgery** to release any information (via mail or fax) including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such Dental/Medical care to third party payors, and other entities and/or health practitioners. I authorize and hereby request my insurance company to pay directly to **Columbus Oral & Maxillofacial Surgery** insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of Patient

Signature of Guardian (if minor)

Date

HEALTH HISTORY

Patient's Name	Date of Birth	Height	Weight	Date
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Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

- I. Are you taking or **have you ever taken** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa) ?Y N
- J. Have you ever been advised not to take a medication?Y N
- K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: _____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
 - A. Rheumatic Fever or Rheumatic Heart Disease?.....Y N
 - B. Congenital Heart Disease?Y N
 - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?.....Y N
 - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?.....Y N
 - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
 - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?.....Y N
 - G. Liver Disease (Jaundice, Hepatitis)?.....Y N
 - H. Kidney Disease?Y N
 - I. Diabetes?Y N
 - J. Thyroid Disease (Goiter)?Y N
 - K. Arthritis?Y N
 - L. Stomach Ulcers or Colitis?Y N
 - M. Glaucoma?Y N
 - N. Osteoporosis?Y N
 - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?Y N
 - P. Radiation (X-ray) treatment for Cancer?Y N
 - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
 - R. Sinus or Nasal problems?Y N
 - S. **MRSA** or any disease, drug or transplant operation that has depressed your immune system?.....Y N

8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
 - A. Local Anesthesia (Novacain, etc.)?.....Y N
 - B. Penicillin or other antibiotics?Y N
 - C. Sedatives, Barbiturates?Y N
 - D. Aspirin or Ibuprofen?.....Y N
 - E. Codeine or other pain killers?.....Y N
 - F. Latex or Rubber products?.....Y N
 - G. Metal of any kind?Y N
 - H. Chemicals or jewelry (rash or sensitivity)?Y N
 - I. Food products?Y N
 - J. Other allergies or reactions? Please list.....Y N

9. Do you smoke or chew Tobacco?Y N
How much per day? _____
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?Y N
11. Have you had any serious problems associated with any previous dental treatment?Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.....Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
14. Do you wish to talk to the doctor privately about anything?Y N
15. Have you ever had a bone density scan?Y N

7. **ARE YOU USING ANY OF THE FOLLOWING:**
 - A. Antibiotics?Y N
 - B. Anticoagulants (Blood Thinners)?Y N
 - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.....Y N
 - D. High Blood Pressure medications?Y N
 - E. Steroids (Cortisone, Prednisone, etc.)?Y N
 - F. Tranquilizers?.....Y N
 - G. Insulin or Oral Anti-Diabetic drugs?.....Y N
 - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N

16. **FOR WOMEN ONLY**
 - A. Are you Pregnant, or **is there any chance** you might be Pregnant?Y N
 - B. Are you nursing?Y N
 - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

Do you brush and floss Y N

I understand the importance of a truthful and complete Health History to assist my Oral Surgeon in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date	Signature of Person Completing Health History	Doctor's Initials
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OVER

Chief Dental, Oral Surgery or Cosmetic Complaint or reason for visit:

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date: _____ Patient's Signature: _____