ORAL SURGERY/IMPLANT CONSULTATION

Form 401C

This questionnaire was designed to provide important facts regarding the history of your pain or condition The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ BIRTH DATE: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN 3-YEARS PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS _____

EMPLOYED BY: _____ OCCUPATION _____

ADDRESS: _____

REFERRED BY: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY: _____

ADDRESS IF DIFFERENT FROM PATIENT _____

FAMILY PHYSICIAN _____

ADDRESS _____

FAMILY DENTIST _____

ADDRESS _____

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

Yes ☐ *No* ☐ Diet limited to semisolid food or soft foods
Yes ☐ *No* ☐ Diet limited to liquid foods
Yes ☐ *No* ☐ Difficulty chewing
Yes ☐ *No* ☐ Difficulty speaking
Yes ☐ *No* ☐ Difficulty swallowing
Yes ☐ *No* ☐ Digestive problems
Yes ☐ *No* ☐ Facial pain
Yes ☐ *No* ☐ Gagging easily
Yes ☐ *No* ☐ Head pain
Yes ☐ *No* ☐ Jaw clicks
Yes ☐ *No* ☐ Jaw locks
Yes ☐ *No* ☐ Limited opening of jaw
Yes ☐ *No* ☐ Loss of teeth
Yes ☐ *No* ☐ Are you currently in pain? _____
Yes ☐ *No* ☐ Do you feel your oral condition is affecting your general health in any way? _____

Yes ☐ *No* ☐ Mouth sores
Yes ☐ *No* ☐ Numbness in lower lip
Yes ☐ *No* ☐ Numbness in jawbone
Yes ☐ *No* ☐ Tingling in jawbone
Yes ☐ *No* ☐ Nutritional disorders
Yes ☐ *No* ☐ Pain in jaw bone
Yes ☐ *No* ☐ Pain in jaw joint
Yes ☐ *No* ☐ Pain when swallowing
Yes ☐ *No* ☐ Pain when chewing
Yes ☐ *No* ☐ Poorly fitting dental appliance ☐ upper ☐ lower
Yes ☐ *No* ☐ Teeth do not meet properly
Yes ☐ *No* ☐ Other

Patient Signature _____ Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Aspirin
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Codeine
Y ☐ N ☐ Iodine
Y ☐ N ☐ Latex
Y ☐ N ☐ Local anesthetics
Y ☐ N ☐ Other _____

Y ☐ N ☐ Metals
Y ☐ N ☐ Penicillin
Y ☐ N ☐ Plastic
Y ☐ N ☐ Sedatives
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Barbiturates
Y ☐ N ☐ Blood thinners
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Other _____

Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Nerve pills
Y ☐ N ☐ Pain medication
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs
Y ☐ N ☐ Tranquilizers

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:

Practitioner Specialty Treatment & Approximate date

_____
_____
_____
_____

MEDICAL HISTORY (Please indicate dates on questions checked YES)

Y ☐ N ☐ Abnormal bleeding after surgery or injury
Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Bloating
Y ☐ N ☐ Blood pressure ☐ High ☐ Low
Y ☐ N ☐ Bruising easily
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic Bronchitis
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Chronic mouth dryness
Y ☐ N ☐ Cold hands & feet
Y ☐ N ☐ Colitis
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Depression
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy

Y ☐ N ☐ Excessive thirst
Y ☐ N ☐ Fainting spells
Y ☐ N ☐ Fluid retention
Y ☐ N ☐ Frequent cough
Y ☐ N ☐ Frequent illnesses
Y ☐ N ☐ Frequent stressful situations
Y ☐ N ☐ General anesthesia
Y ☐ N ☐ Glaucoma
Y ☐ N ☐ Gout
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Headaches
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart palpitations
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Heart valve damaged
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Hypoglycemia
Y ☐ N ☐ Immune system disorder

Y ☐ N ☐ Injury to ☐ Face ☐ Mouth ☐ Neck ☐ Teeth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Kidney problems
Y ☐ N ☐ Liver disease
Y ☐ N ☐ Meniere's disease
Y ☐ N ☐ Menstrual cramps
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle aches
Y ☐ N ☐ Muscle shaking (tremors)
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Muscular dystrophy
Y ☐ N ☐ Needing extra pillows to help breathing at night
Y ☐ N ☐ Nervous system irritability
Y ☐ N ☐ Nervousness
Y ☐ N ☐ Neuralgia
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Ovarian cysts
Y ☐ N ☐ Parkinson's disease

Other _____

Patient Signature _____ Date _____

MEDICAL HISTORY Continued

Y☐ N☐ Poor circulation
Y☐ N☐ Prior orthodontic treatment
Y☐ N☐ Psychiatric care
Y☐ N☐ Radiation treatment
Y☐ N☐ Rheumatic fever
Y☐ N☐ Rheumatoid arthritis
Y☐ N☐ Scarlet fever

Y☐ N☐ Seizures
Y☐ N☐ Shortness of breath
Y☐ N☐ Sickle Cell Anemia
Y☐ N☐ Sinus problems
Y☐ N☐ Skin disorder
Y☐ N☐ Slow healing sores
Y☐ N☐ Speech difficulties
Y☐ N☐ Stomach ulcers
Y☐ N☐ Stroke

Y☐ N☐ Swelling of ankles
Y☐ N☐ Swollen, stiff or painful joints
Y☐ N☐ Tendency for:
  Y☐ N☐ Frequent Colds
  Y☐ N☐ Ear Infections
  Y☐ N☐ Sore Throats
Y☐ N☐ Tired muscles
Y☐ N☐ Tuberculosis
Y☐ N☐ Tumors
Y☐ N☐ Urinary disorders

Y☐ N☐ Other Medical/Dental History _____

Do you take aspirin regularly ☐ Yes ☐ No Smoke tobacco ☐ Yes ☐ No

Has any close relative had a serious illness or condition ☐ Yes _____ ☐ No

Emotional or nervous disturbances? ☐ Yes ☐ No

If yes, please explain _____

COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THIS VISIT
THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:

☐ A motor vehicle accident
☐ A motorcycle accident
☐ A work related incident
☐ A playground incident
☐ An athletic endeavor
☐ A fight
☐ A fall
☐ An accident
☐ Unknown
☐ Other _____

DATE OF ACCIDENT OR INCIDENT: _____

HISTORY OF ACCIDENT

WERE YOU ?

☐ A passenger in a vehicle
☐ The driver of a vehicle
☐ A pedestrian
☐ At work
☐ Did you fall?
☐ Were you hit by an object?
☐ Did you hit an object?
☐ Other _____

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

☐ At front end
☐ At rear end
☐ At front right area
☐ At front left area
☐ At rear right area
☐ At rear left area
☐ Head on
☐ On driver's side
☐ On passenger's side
☐ Other _____

INDICATE IF THERE WAS ANY DIRECT TRAUMA:

DID YOUR
☐ Forehead
☐ Face
☐ Chin
☐ Side of head
☐ Back of head
☐ Top of head
☐ Teeth
☐ Jaw
☐ Other _____

FORCIBLY STRIKE
☐ Steering wheel
☐ Windshield
☐ Passenger's side window
☐ Driver's side window
☐ Passenger's side door
☐ Driver's side door
☐ Headrest
☐ Seat
☐ Roof
☐ Interior of car
☐ Other _____

TEETH WERE
☐ Sore
☐ Missing
☐ Loose
☐ Broken
☐ Other _____

AFTER THE ACCIDENT

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: _____

_____

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Extent of medical history obtained on _____ *(date) consisted of:*

☐ Chief Complaint(s) ☐ Extended history of present illnesss
☐ Review of systems related to problem ☐ Review of all additional body systems
☐ Complete past history ☐ Complete family history ☐ Complete social history

Patient Signature _____ Date _____

FAMILY HISTORY

Have any members of your family (blood kin) had:

Y☐ N☐ Headaches
Y☐ N☐ Heart disease
Y☐ N☐ High blood pressure
Y☐ N☐ Diabetes

SOCIAL HISTORY

Occupation _____

Do you have children? Y☐ N☐ If yes, how many children? _____ What are their ages? _____

Y☐ N☐ Are you currently under unusual stress?
Y☐ N☐ Recent change in lifestyle?
Y☐ N☐ Do you exercise regularly?

Y☐ N☐ Do you chew tobacco?

Number of caffeine drinks per day _____

Y☐ N☐ Do you smoke?

_____ *Number of* ☐ Packs ☐ Cigarettes *per* ☐ Day ☐ Week

Alcohol consumption

_____ *Number of drinks per* ☐ Day ☐ Week ☐ Month

INSURANCE INFORMATION

INSURANCE #1 (MEDICAL/DENTAL/AUTO/OTHER)

Insured's Name _____ Insured's Social Security No. _____

Relationship _____ Insured's Birth date. _____

Insured's Street Address _____

City, State, Zip _____

Insurance Company _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No. _____

MEDICAL INSURANCE #2 (MEDICAL/DENTAL/AUTO/OTHER)

Insured's Name _____ Insured's Social Security No. _____

Relationship _____ Insured's Birth date. _____

Insured's Street Address _____

City, State, Zip _____

Insurance Company _____

Insurance Billing Address _____

City, State, Zip _____

Policy No. _____ Group No. _____ I.D. No. _____

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Signed _____ Date _____

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Insurance Company _____

☐ Group Health ☐ Auto ☐ Government ☐ Self Insured ☐ Dental

Contact Person _____ Phone No. _____ Today's Date _____

Effective date of this policy _____ Policy exclusions _____

Amount of deductible? _____ Has it been satisfied? _____

At what percentage are benefits paid? _____

Policy maximum? _____

Is precertification required ☐ Yes ☐ No Can benefits be assigned to doctor? ☐ Yes ☐ No

What information is needed to process this claim? _____

For No Fault: Amount of benefits _____ Adjuster _____

Other _____