ORAL & MAXILLOFACIAL SURGERY ASSOCIATES

4850 N. 9th Avenue, Bldg. #4
Pensacola, FL 32503

Dr. **MSG / KCD**

Date: _____

Patient Name: _____ Age: ____ Date of Birth: _____

□Mr. □Mrs. □Miss □Ms. □Married □Single □Divorced □Widowed □Separated

Patient's SS#: _____ Sex: ( ) Male ( ) Female Height: ____ ft ____in Weight: _____lb

Patient's Address: _____ City: _____ State: ____ Zip: _____

(NO P.O. Boxes)

Patient's Phone: (___) _____ Email: _____ Cell: (___) _____

Patient's Employer: _____ Employer Address: _____ Patient's Occupation: _____

Person we can contact in case of emergency: _____ Phone: _____

Patient's Physician/MD: _____ Other Physician: _____

Patient's Dentist: _____ Patient referred by: _____

If under age 18, who is responsible for paying account? (Guarantor) ( ) Self ( ) Spouse ( ) Father ( ) Mother ( ) Legal Guardian

Guarantor's Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (___) _____ Email: _____ Cell: (___) _____ Date of Birth: _____

********If legal guardian, must provide legal documentation for office to copy*********

PRIMARY INSURANCE COMPANY:

Insurance Company Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____

ID#/Policy#/Subscriber#/SS#: _____

Group#: _____ Group Name: _____

Is this an Employer Health Insurance Plan? ( ) No ( ) Yes

Phone#: _____ Street: _____ City: _____ State: ___ Zip: _____

Does your plan cover: ( ) Medical ( ) Dental ( ) Both

Policy Holder Name: _____

Your relation to insured: ( ) self ( ) spouse ( ) child ( ) other

Date of Birth Of Insured: _____

Policy Holder Address: _____

_____

Phone #: _____

Employer Name: _____

SECONDARY INSURANCE COMPANY:

Insurance Company Name: _____

Insurance Address: _____

_____

Insurance Phone #: _____

ID#/Policy#/Subscriber#/SS#: _____

Group#: _____ Group Name: _____

Is this an Employer Health Insurance Plan? ( ) No ( ) Yes

Phone#: _____ Street: _____ City: _____ State: ___ Zip: _____

Does your plan cover: ( ) Medical ( ) Dental ( ) Both

Policy Holder Name: _____

Your relation to insured: ( ) self ( ) spouse ( ) child ( ) other

Date of Birth Of Insured: _____

Policy Holder Address: _____

_____

Phone #: _____

Employer Name: _____

****Describe patient's present problem:** _____

****When did the symptoms first occur:** _____

DENTAL/MEDICAL HISTORY: Do you have **OR** have you **EVER** had any of the following:
(Please circle **Yes OR No**)

Cardiovascular (Heart):

Heart murmur	Yes / No
Mitral valve prolapse	Yes / No
Congenital heart lesion	Yes / No
High blood pressure	Yes / No
Heart disease/heart attack	Yes / No
Heart valve	Yes / No
Coronary occlusion	Yes / No
AFIB	Yes / No
Taking blood thinners	Yes / No

Endocrine:

Diabetes/take insulin	Yes / No
Thyroid disease	Yes / No

Hematologic:

Anemia	Yes / No
Sickle cell anemia	Yes / No

Respiratory:

Shortness of breath	Yes / No
Respiratory illness	Yes / No
COPD	Yes / No
Sleep apnea	Yes / No
Asthma	Yes / No
Hives/skin rash	Yes / No
Allergies/hay fever	Yes / No
Tuberculosis	Yes / No
Chronic sinusitis	Yes / No

Neurological/Psychiatric:

Aneurysm	Yes / No
Autism	Yes / No
Bipolar	Yes / No
Parkinson's disease	Yes / No
Anxiety/depression	Yes / No
Dementia/Alzheimers	Yes / No
Multiple sclerosis	Yes / No
Epilepsy	Yes / No
Asperger's Syndrome	Yes / No
ADD/ADHD	Yes / No
Cerebral Palsy	Yes / No
Seizures	Yes / No
Stroke/TIA	Yes / No

Musculoskeletal:

Arthritis (painful joints)	Yes / No
Osteoporosis/osteopenia	Yes / No
Rheumatic fever	Yes / No
Inflammatory rheumatism	Yes / No
Implants (hip replacement , knee, etc) ,	Yes / No

Immunologic:

HIV/AIDS	Yes / No
Lupus	Yes / No
STDs	Yes / No
History of cancer	Yes / No
History of chemo	Yes / No
History of radiation	Yes / No

Renal/Kidney:

Kidney disease/failure	Yes / No
Renal failure	Yes / No
Dialysis	Yes / No

Gastrointestinal:

Crohn's disease	Yes / No
Hepatitis A or B	Yes / No

Vision:

Glaucoma	Yes / No
Eye surgery (last 8 weeks)	Yes/ No

Integumentary:

Jaundice/liver disease	Yes / No

Women only:

Pregnant	Yes / No
Breast feeding	Yes / No
Birth control pills	Yes / No

History of:

Measles, mumps, chicken pox	Yes / No
Chronic sore throat	Yes / No
Illicit/recreational use of drugs(cocaine, illegal narcotics, etc.)	Yes / No
Popping/clicking when chewing in the jaw	Yes / No
Clenching teeth	Yes / No

HOSPITALIZATIONS/OPERATIONS: Please list any hospitalizations or operations that you have had:

Date	Hospital	Surgery/Operation

SOCIAL HISTORY:

***Have you ever smoked, vaped, or chewed tobacco:** Yes / No
If yes, for how long? _____

***Have you ever sought professional care or been hospitalized for:**

Alcoholism	Yes / No
Substance abuse	Yes / No
Emotional disorders	Yes / No

***Do you use:**

Alcohol	Yes / No	if yes, how often ____
Marijuana	Yes / No	if yes, how often ____
Recreational drugs	Yes / No	if yes, how often ____

ALLERGIES: – Are you allergic to any of the following or reacted adversely to any of the following:

Local anesthetics (e.g. Novacain)	Yes / No	Codeine / Demerol	Yes / No
Penicillin	Yes / No	Aspirin	Yes / No
Clindamycin	Yes / No	Ibuprofen (Motrin)/Naproxen (Aleve)	Yes / No
Doxycycline	Yes / No	Antidepressants	Yes / No
Sulfur	Yes / No	Sedatives/Barbiturates	Yes / No
Latex	Yes / No	Any other pain medications: _____	
Iodine	Yes / No	_____	

Any other allergies (please explain): _____

_____

PLEASE LIST ALL MEDICATIONS: Please circle YES / NO beside any medications of the list that you are taking OR list any out to the side that are not on the list:

Antibiotics or sulfa drugs	Yes / No	_____
Anticoagulants/blood thinners	Yes / No	_____
High blood pressure medication	Yes / No	_____
Antidepressants/tranquilizers	Yes / No	_____
Steroids/Cortisone	Yes / No	_____
Insulin, Tolbutamide, Orinase	Yes / No	_____
Seizure medication	Yes / No	_____
Heart medications (Digitalis)	Yes / No	_____
Nitroglycerin	Yes / No	_____
Diet pills (Phentermine, etc)	Yes / No	_____
Methadone/Suboxone	Yes / No	_____
Herbal medications(echinacea, garlic ginseng, ginko, kava, ephedra)	Yes / No	_____
		_____
Osteoporosis/bisphosphonates	Yes / No	_____

□Fosamax □Boniva □Reclast □Actonel □Didronel □Skelid □Aredia □Zometa

If you have any disease, condition or problem, not listed above, that we should know about or if you need to speak privately with the doctor about, please explain: _____

_____

**Is this visit related to an accident? Auto: ( ) Yes ( ) No Other: _____

Date of injury: _____

Our prescriptions are now being sent electronically, so please make sure information is correct on all forms

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address/Location: _____

I understand the information I provide on this form is essential to determine my dental needs and the provision of treatment and that if any change occurs in my health, I will report it to the office as soon as possible. I have read and understand this form and answered the questions truthfully and to the best of my ability and I understand that I will have the opportunity to discuss my health information with my doctor. I understand that I may be prescribed a narcotic or sedative medication as part of my treatment program for managing my pain. I realize that these medications have potentially serious side effects, including: sedation or drowsiness, confused thinking, possible tolerance, possible addiction. While taking these medications, I have been told that I should: avoid the use of alcohol, avoid driving or operating hazardous machinery, and not make important decisions or sign legal contracts.

I hereby state that I understand the above medical history questionnaire and grant authority to Dr. Mark S. Greskovich and /or Dr. Kevin C. Dean and/or the doctor in charge of the care of this patient whose name appears on this form to administer such anesthetics, to perform such operations, and to take such radiographs, as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I also agree I am responsible for payment of this account.

How paying today: Cash □ Credit □ (a 4% convenience fee will be assessed on all credit card transactions) **NO PERSONAL CHECKS**

Signature of Patient/or Legal Guardian	Relationship to Patient	Date
Dr's Initials:		

O.M.F.S. CONSULT

DR. □ **MSG** □ **KCD**

NAME _____ **DATE:** _____
DR REQUESTING CONSULT: _____
CC _____

_____

HPI _____ **Ht murmur hx/ SBE**
_____ + / - / + / -
PMHX _____
PSHX _____
ALLERGIES _____

_____

MEDS _____

_____

P.E. – EXTRAORAL _____

_____

INTRAORAL _____

_____

_____

_____

_____

RADIOGRAPH _____

_____

DQ Requirements: _____
□ **Anxiety w/ failure of N2O** _____
□ **Management & behavior issues** _____
□ **3 yrs. or less w/ extensive treatment** _____
□ **Infection/cellulitis/abscess present** _____
DIAGNOSIS _____

_____

RECOMMENDED TX _____

_____

_____

_____

_____

RISKS EXPLAINED: PERM. NLTC/LT/OA FISTULA __

_____

Anesthesia: _____ **Units** □1 □2 □3 □4
Sx Time: □ **10 min** □ **20 min** □ **30 min**
□ **40 min** □ **50 min** □ **60 min**
Impactions: Difficult _____ **Full** _____
Partial _____ **Tissue** _____
Deciduous tooth/crown _____
Extraction/exposed root _____

_____

_____

Surgical removal erupted _____

_____

_____

Res. Roots □ **Sx.** _____
Alveo _____**4+ ext/spaces** □ **UR** □**UL** _____**1-3ext/spaces**
w/out _____**4+ spaces** □ **LR** □ **LL** _____**1-3 spaces**
Osteoma □ **Max** □ **Mand** // **Tori** □ **Max** □ **Mand**
Cyst/Tumor _____ **> < 1.25**
Biopsy □ **Exc /** □ **Inc** □ **soft tissue /** □ **bone**

_____

Frenuloplasty _____ **Frenectomy** _____
□ **Lingual** _____ □ **Labial** _____
Exposure _____ **w/attachment** _____
I & D _____ □ **intraoral /** □ **extraoral**
RCT-Apico _____ □ **1 root** □ **2 roots** □ **3 roots** _____
Implants □ **immediate /** □ **delay** _____

_____

Bone Graft _____
Fx: _____ **Lacerations:** _____

_____

SHSC □ **SHH** □ **Total Time:** _____ **Minutes**
H & P: □ **MSG/KCD** □ **PCP** □ **Cardio** □ **Other**
Dx: _____

_____

_____

3D CT _____ **OG** _____

****

1.	Amoxicillin	500mg	#21	tid	
2.	Amoxicillin	□2grams (4 tabs)		po 1 hour prior	
3.	Amoxicillin	250mg	#21	tid	
4.	Amoxicillin Elixir	250mg/5cc	150cc	5cc/tid	
5.	Amoxicillin Elixir	125mg/5cc	150cc	5cc/tid	
6.	Keflex	500mg	#28	qid	
7.	PenVK	500mg	#28	qid	
8.	Doxycycline	100mg	#14	bid	
9.	Zithromax	250mg		as directed	
10.	Cleocin	150mg	#21	tid	
11.	Cleocin	□ 600mg (4tabs)		po 1 hour prior	
12.	Cleocin Elixir	75mg/5cc	#200cc	10cc/tid	
13.	Flagyl	500mg	#24	tid	
14.	Augmentin	875mg	#14	bid	
15.	Tramadol	50mg	#20	1 q6h prn pain	
16.	Tylenol#3 w/ Codeine	#20		1 q 4-6h prn pain	
17.	Tylenol Elixir w/ Codeine	#100cc		5cc q 3-4hprn pain	
18.	Hydrocodone	7.5mg	#20	q 4hprn pain	
19.	Hydrocodone elixir	2.5mg/5cc	#200cc	10cc q3-4h prn pain	
20.	Demerol	50mg	#20	1 po q 6 prn pain	
21.	Dilaudid	4mg	#20	1 po q 6 prn pain	
22.	Promethazine	25mg	1/2tabpo q6 prn nausea/vomiting		
23.	Zofran	4mg	#____	q 6h prn nausea/vomiting	
24.	Flexeril	10mg	#30	tid	
25.	Xanax	1.0mg		# ___ q h s-q AM	
26.	Percocet	7.5mg/325mg	#24	q4-6h prn pain	
27.	Peridex	1 bottle	□ refill #___	1/2oz tid	
28.	Dexamethasone Elixir	0.5mg/5cc/300cc		10cc/swish/spit bid	
29.	Dexamethasone Dose Pack			as directed	
30.	Motrin	600mg	#30	q 6h prn pain	
31	.Nystatin	100,000 units/ML	280ML	5ML po swish 5 min/spit qid	
32.	Ultracet	37.5/325mg	#20	1-2 q6h prn pain	