

**ORAL SURGERY SERVICES, INC.**

**PLEASE PRINT CLEARLY**

Patient's Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of Parent or Spouse \_\_\_\_\_

Employer of Parent or Spouse \_\_\_\_\_

Address \_\_\_\_\_

Name of Person Responsible for Payment of Bill \_\_\_\_\_

Name of Agency Responsible for Payment of Bill (Check one if applicable)

Blue Shield Number \_\_\_\_\_

Medical Assistance Number \_\_\_\_\_

Dental Insurance Name \_\_\_\_\_ Number \_\_\_\_\_

Name of Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Name of Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Do you have or have you ever had:

	YES	NO		YES	NO
Anemia	___	___	Lung Disease	___	___
Diabetes	___	___	Abnormal Blood Pressure	___	___
Hepatitis	___	___	Kidney Disease	___	___
Epilepsy	___	___	Liver Disease	___	___
Rheumatic Fever	___	___	Thyroid Trouble	___	___
Asthma	___	___	Heart Trouble	___	___
Prolonged Bleeding	___	___	Nervous Disorders	___	___

Are you under treatment by a physician? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

Are you presently taking cortisone, predisone, steroids? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Which ones: \_\_\_\_\_

Have you used any recreational drugs within the past 72 hours? \_\_\_\_\_ IF YES, PLEASE CHECK

Marijuana  Narcotics  Cocaine  Mescaline  Barbiturates  Amphetamines  Other \_\_\_\_\_

The use of any of the above drugs can be dangerous in conjunction with General Anesthetic drugs.

Are you pregnant? \_\_\_\_\_ Number of Months: \_\_\_\_\_

Do you have a cold or other respiratory problem? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Do you have "smoker's cough?" \_\_\_\_\_

A. Have you had anything to eat or drink within the last 6 hours? \_\_\_\_\_

B. Are you wearing dentures? \_\_\_\_\_ C. Who is to drive you home today? \_\_\_\_\_

Any other medical conditions? \_\_\_\_\_

Please explain: \_\_\_\_\_

The information given above is, to the best of my knowledge, complete and true.

Signature \_\_\_\_\_ Date \_\_\_\_\_