UTAH FACIAL & ORAL SURGERY
CHRISTOPHER PRICE, DDS, MD

General Patient Information

Patient's Full Name: _____ Date: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ SS #: _____

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

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Occupation: _____ Employer: _____

Email Address: _____ Referring Doctor: _____

RESPONSIBLE PARTY (FINANCIAL):

Name: _____ Sex: ☐ M ☐ F Date of Birth: _____

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

Home Phone: _____ Work Phone: _____ SS #: _____

Employer: _____

Please list any family members we have seen: _____

INSURANCE INFORMATION:

Primary Dental Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID #: _____ Group ID#: _____

Secondary Dental Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID #: _____ Group ID#: _____

Primary Medical Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID #: _____ Group ID#: _____

Secondary Medical Insurance: _____ Insurance Ph#: _____

Insurance Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID #: _____ Group ID#: _____

Date: _____ **Patient's Signature:** _____

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Health History

***For the following questions, check yes or no, whichever applies. Your answers are for our records only and will be kept confidential.**

ALLERGIES & MEDICATION:

Are you allergic to or have you had a reaction to:

- ☐ Local Anesthetics
- ☐ Penicillin or Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates or Sleeping Pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine or Other Narcotics
- ☐ Latex or Rubber Products
- ☐ Other (List below)

Please list all other known allergies: _____

_____

Pleast list any medicine(s) you are taking including diet pills, non-prescription, vitamins, homeopathic, or natural remedies: _____

_____

What is the reason for today's visit? _____

- Are you now under the care of a physician? ..... ☐ Yes ☐ No
  If so, for what condition?: _____
- Have you had any serious illness, operation, or hospitalization within the past 5 years? ..... ☐ Yes ☐ No
- Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ..... ☐ Yes ☐ No
- Are you taking or have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, or Zometa)? ..... ☐ Yes ☐ No
- Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? ..... ☐ Yes ☐ No
- Are you taking any blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko)? ..... ☐ Yes ☐ No
- Have you ever taken tranquilizers, sleeping pills, antidepressants, or narcotics? ..... ☐ Yes ☐ No
  If so, please list: _____
- Have you had any serious trouble associated with previous dental treatment? ..... ☐ Yes ☐ No
- Are you wearing removable dental appliances? ..... ☐ Yes ☐ No
- Are you wearing contact lenses? ..... ☐ Yes ☐ No
- Do you have or have you had any of the following diseases or problems?

  - ☐ Damaged Heart Valves, Artificial Valves, or Heart Murmur
  - ☐ Rheumatic Heart Disease
  - ☐ Heart Trouble or Heart Attack
  - ☐ Angina
  - ☐ High/Low Blood Pressure
  - ☐ Stroke
  - ☐ Arteriosclerosis or Any Other Heart Condition
  - ☐ Chest Pain Upon Exertion
  - ☐ Shortness of Breath After Mild Exercise
  - ☐ Swelling of Ankles
  - ☐ Allergies
  - ☐ Sinus Trouble
  - ☐ Asthma or Hay Fever
  - ☐ Fainting Spells or Seizures
  - ☐ Diabetes
  - ☐ Hepatitis, Jaundice, or Liver Disease
  - ☐ Thyroid Problems
  - ☐ Respiratory Problems, Emphysema, Bronchitis, etc.
  - ☐ Arthritis or Painful, Swollen Joints Including Jaw Joint (TMJ)
  - ☐ Osteoporosis
  - ☐ Stomach Ulcer or Hyperacidity
  - ☐ Kidney Trouble
  - ☐ Tuberculosis
  - ☐ Persistent Cough or Cough That Produces Blood
  - ☐ Persistent, Swollen Neck Glands
  - ☐ Epilepsy or Neurological Disorder
  - ☐ Cancer
  - ☐ Blood Disorder (e.g., Anemia)
  - ☐ Required a Blood Transfusion
  - ☐ Treatment For a Tumor or Growth
  - ☐ Radiation Therapy to the Head, Neck, or Jaws
  - ☐ Depressed Immune System (From Disease, Drug, or Transplant)
  - ☐ Alcohol/Chemical Dependency
  - ☐ Smoke or Chew Tobacco (If so, how much?: _____)

- Do you have any other condition or disease you think the doctor should know about? ..... ☐ Yes ☐ No
  If so, explain: _____
- Do you wish to talk with the doctor privately about anything?..... ☐ Yes ☐ No

WOMEN ONLY:

- ☐ Pregnant or Trying to Become Pregnant
- ☐ Problems Associated with Menstrual Period
- ☐ Nursing
- ☐ Taking Birth Control Pills

ACCIDENT-RELATED VISIT:

Date of Injury: _____ Insurance Company Handling This Claim: _____

Claim Number: _____ Insurance Address: _____

Name of Attorney/Adjustor: _____ Telephone Number: _____

***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:** _____