PHARMACY INFORMATION

PATIENT NAME: _____

DOB: _____

PATIENT PHONE NUMBER: _____

PHARMACY OF CHOICE: _____

FULL ADDRESS: _____

PHONE NUMBER: _____

I consent to the information provided above is correct and give San Tan Oral Surgery permission to submit all given prescriptions electronically to the pharmacy I have listed.

PATIENT SIGNATURE: _____

DATE: _____

HEALTH HISTORY

PATIENT NAME_____ BIRTHDATE___/___/___ PATIENT #_____

This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. This is a confidential part of your medical record and will be kept in this office.

Today's date_____
Occupation_____
Previous occupations_____
Marital status_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Street drugs (type & amount per day)_____
Usual weight_____My ideal weight_____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)

_____
_____
_____

Are you now or have you ever been treated for substance abuse?_____ If yes, What for ?_____
Treatment facility or Doctor name and contact info:

_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:

_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs):

_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

_____
_____
_____

When was your last physical exam?_____
Name of doctor_____Phone_____
Any history of family violence?_____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	system problems	no	yes	Stroke	no	yes
Mumps	no	yes	Cancer	no	yes	Hepatitis	no	yes
Chickenpox	no	yes	Polio	no	yes	Ulcer	no	yes
Scarlet Fever	no	yes	Glaucoma	no	yes	Kidney disease	no	yes
Diptheria	no	yes	Sinus problems	no	yes	Thyroid Disease	no	yes
Smallpox	no	yes	Blood or Plasma Transfusions	no	yes	Bleeding Tendency	no	yes
Pneumonia	no	yes	Back trouble	no	yes	Any other Disease	no	yes
Rheumatic Fever	no	yes	High/low Blood Pressure	no	yes			
Heart Disease	no	yes	Artificial joints	no	yes	(Please list)		
Arthritis	no	yes	MS/MD/Cerebral Palsy	no	yes	_____		
Venereal Disease	no	yes	Asthma	no	yes	Date of last Chest x-ray:		
Anemia	no	yes	Psychiatric care	no	yes	_____		
Hemophilia	no	yes	AIDS or HIV+	no	yes	Are you pregnant?	no	
Pacemaker	no	yes	Infectious Mono	no	yes		yes	
Epilepsy	no	yes	Bronchitis	no	yes	Allergies to anesthetics	no	yes
Migraine Headaches	no	yes	Mitral Valve Prolapse	no	yes			
Tuberculosis	no	yes						
Diabetes	no	yes						
nervous								

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature_____Date_____

Physicians Signature_____

MEDICAL CLEARANCE FORM

On the **Medical History Form** you completed, you identified that you have one or more coronary or other medical risk factors which could affect your planned dental treatment. For this reason, we ask that you have a physician complete and return this medical clearance form to us so that we can begin your planned treatment. We sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your dental care at our office to be as safe and comfortable as possible.

I hereby give my permission to release any pertinent medical information from medical records to Dr. _____ & staff at this office. All information will remain confidential.

Patient's name (print): _____ **Date:** _____ **DOB:** _____

Physician's name: _____ **Phone:** _____

Address: _____

PHYSICIAN USE ONLY Our mutual patient, _____ is scheduled for dental treatment.

Treatment may include:

____Cleaning (*simple or deep*)
____Radiographs
____Fillings, crowns, bridge
____Local anesthetic w/epinephrine
____Periodontal surgery
____IV sedation
____Root Canal Therapy
____Nitrous Oxide
____Dental implant surgery
____Extraction (*simple or surgical*)
____Oral sedation

Please evaluate the patient's medical history & advise us of any special considerations that should be made:

_____

Antibiotic Prophylaxis: ___Yes ___No
Interruption of anticoagulants: ___Yes ___No
If yes, how long after treatment? _____
Anesthetic Restrictions: ___Yes ___No
Epinephrine Restrictions: ___Yes ___No

Type of antibiotic allowed/recommended: _____

Type of pain medication allowed/recommended: _____

Any additional comments: _____

Physician's name *(print):* _____

Physician's signature: _____ Date: _____

Please return this form to: