ANDREW R. RAHN DDS. P.C.

ORAL & MAXILLOFACIAL SURGERY · BOARD CERTIFIED

To our patients: Although oral surgeons treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. All answers contained are strictly confidential and will become part of your medical record. Thank you!

PATIENT INFORMATION				
Name: *(First M.I. Last)* ☐ M ☐ F			**DOB:**	**Age:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Social Security #:		**E-mail:**		
Address	**Apt:**	**City:**	**State:**	**Zip:**
Home Phone: ( )	**Cell Phone: ( )**		**Work Phone: ( )**	
Employer:	**Student:** ☐ Full time ☐ Part time		**School:**	

Name of Dentist:	**Name of Orthodontist:**
Name of Physician:	**Date of last physical exam:**
Referred by:	**Pharmacy:**

Emergency Contact Name: *(First M.I. Last)*	**Phone Number: ( )**

RESPONSIBLE PARTY'S BILLING INFORMATION (*IF DIFFERENT FROM ABOVE*)				
Name: *(First M.I. Last)* ☐ M ☐ F			**DOB:**	
Address	**Apt:**	**City:**	**State:**	**Zip:**
Home Phone: ( )	**Cell Phone: ( )**		**Work Phone: ( )**	
Social Security #:		**Employer:**		

Spouse's Name: *(First M.I. Last)* ☐ M ☐ F			**DOB:**
Home Phone: ( )	**Cell Phone: ( )**		**Work Phone: ( )**
Social Security #:		**Employer:**	

PRIMARY DENTAL INSURANCE COMPANY		**PRIMARY MEDICAL INSURANCE COMPANY**	
Insurance Company:		**Insurance Company:**	
Subscriber's Name:		**Subscriber's Name:**	
SS#:	**DOB:**	**SS#:**	**DOB:**
Group #:		**Group #:**	
Employer:		**Employer:**	
Relation to Patient:		**Relation to Patient:**	

SECONDARY DENTAL INSURANCE COMPANY		**SECONDARY MEDICAL INSURANCE COMPANY**	
Insurance Company:		**Insurance Company:**	
Subscriber's Name:		**Subscriber's Name:**	
SS#:	**DOB:**	**SS#:**	**DOB:**
Group #:		**Group #:**	
Employer:		**Employer:**	
Relation to Patient:		**Relation to Patient:**	

PERSONAL HEALTH HISTORY

MALE ___ FEMALE ___ HEIGHT _____ WEIGHT _____ AGE _____

PLEASE CHECK THE BOXES THAT APPLY TO YOUR PAST AND CURRENT HEALTH CONDITIONS:

MEDICAL HISTORY

- ☐ DIABETES
  IF SO: ☐ TYPE 1 ☐ TYPE 2
- ☐ ARTHRITIS
- ☐ PAINFUL/SWOLLEN JOINTS
- ☐ SWOLLEN ANKLES
- ☐ EYE PROBLEMS (GLAUCOMA)
- ☐ STOMACH ULCERS
- ☐ DIARRHEA/CONSTIPATION
- ☐ VOMITING OR ACID REFLUX
- ☐ HEAD OR NECK INJURY
- ☐ NUMBNESS/TINGLING ANYWHERE
- ☐ HEADACHES/MIGRAINES
- ☐ FRACTURE/DISLOCATION
- ☐ WEIGHT CHANGE OVER 20 LBS IN PAST YEAR
- ☐ STROKE
- ☐ AIDS/HIV
- ☐ HEPATITIS
- ☐ JAUNDICE
- ☐ LIVER DISEASE/CIRRHOSIS
- ☐ THYROID PROBLEMS
- ☐ KIDNEY/BLADDER TROUBLE
- ☐ DEFECTIVE IMMUNE SYSTEM
- ☐ EPILEPSY/SEIZURES
- ☐ OSTEOPOROSIS (BISPHOSPHONATES)
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ DATE OF LAST HOSPITALIZATION

_____

RESPIRATORY

- ☐ ASTHMA, DATE OF LAST ATTACK

_____

- ☐ SINUS/NASAL PROBLEMS
- ☐ TUBERCULOSIS
- ☐ PNEUMONIA
- ☐ SHORTNESS OF BREATH
- ☐ CHRONIC COUGH
- ☐ BRONCHITIS
- ☐ EMPHYSEMA
- ☐ SLEEP APNEA
- ☐ I USE A CPAP MACHINE
- ☐ SNORING

ORAL

- ☐ HURTS TO CHEW
- ☐ JAW MAKES CLICKING SOUND
- ☐ TMJ PROBLEMS
- ☐ FREQUENT/RECURRING MOUTH SORES

HEART

- ☐ HEART ATTACK
- ☐ BYPASS/STENT(S)
- ☐ ANGINA/CHEST PAIN
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ RHEUMATIC FEVER
- ☐ HEART MURMUR
- ☐ IRREGULAR HEART BEAT
- ☐ HEART DEFECT
- ☐ PROSTHETIC HEART VALVE
- ☐ PACEMAKER/DEFIBRILLATOR
- ☐ FAINTING/DIZZY SPELLS

BLOOD

- ☐ BRUISE OR BLEED EASILY
- ☐ HEMOPHILIA
- ☐ SICKLE CELL DISEASE
- ☐ ANEMIA
- ☐ BLOOD TRANSFUSION
- ☐ HAVE YOU OR AN IMMEDIATE FAMILY MEMBER HAD ANY PROBLEMS ASSOCIATED WITH MALIGNANT HYPERTHERMIA?

CANCER

- ☐ CHEMOTHERAPHY
- ☐ RADIATION THERAPY
- ☐ SURGERY
- ☐ LEUKEMIA
- ☐ OTHER: _____

MENTAL

- ☐ DEPRESSED/BIPOLAR
- ☐ CHANGE IN MEMORY
- ☐ PANIC ATTACK
- ☐ PSYCHIATRIC CARE OR COUNSELING
- ☐ ADD/ADHD

SURGERIES

- ☐ IMPLANTS
- ☐ PROSTHETIC JOINTS (I.E. HIP, KNEE)
- ☐ ORGAN/BONE MARROW TRANSPLANT
- ☐ VASCULAR OR CARDIAC REPAIR
- ☐ I HAVE HAD GENERAL ANESTHESIA
- ☐ HAVE YOU OR AN IMMEDIATE FAMILY MEMBER HAD ANY PROBLEMS ASSOCIATED WITH INTRAVANEOUS ANESTHESIA?
- ☐ OTHER: _____

HEALTH CONCERNS

- ☐ CONSUMPTION OF ALCOHOL
  HOW MUCH? _____
- ☐ SMOKING/CHEWING TOBACCO
  HOW MUCH? _____
- ☐ RECREATIONAL DRUGS/SUBSTANCES **(MARIJUANA, COCAINE, HEROIN, AMPHETAMINES, ETC)**
  DATE OF LAST USE _____
- ☐ RECOVERING SUBSTANCE ABUSER

FOR FEMALES ONLY

IS IT POSSIBLE YOU ARE PREGNANT?

- ☐ YES
- ☐ NO

IF YES, PLEASE INDICATE DUE DATE:

_____

- ☐ NURSING

ALLERGIES

_____

_____

_____

_____

_____

MEDICATIONS

_____

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DO YOU PREMEDICATE BEFORE DENTAL TREATMENT? ☐ YES ☐ NO

WITH: _____

OTHER HEALTH CONCERNS

_____

_____

_____

PATIENT/GUARDIAN SIGNATURE

DATE _____

_____

DOCTOR SIGNATURE

DATE _____