Welcome to

BEAVERTON ORAL SURGEONS
ORALIS
DENTAL IMPLANT CENTER / WISDOM TEETH

Date / /

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Oral & Maxillofacial Surgeon

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Oral & Maxillofacial Surgeon

If patient is a minor, please complete section II.

I. PATIENT INFORMATION

NAME	Legal First Name	M.I.	Last Name		Nickname	Age
ADDRESS	Street			Apt #		
	City		State	Zip	Sex ☐ Male ☐ Female	
STUDENT?	☐ Yes ☐ No | ☐ Full-time ☐ Part-time	School Name:			Birth date / /	
EMPLOYED?	☐ Yes ☐ No | ☐ Full-time ☐ Part-time ☐ Retired				Social Security # - -	
EMPLOYER	Company		Address		Position	
	City		State	Zip	Work Phone ( )	
MARITAL STATUS?	☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Single				Cell Phone ( )	
EMERGENCY CONTACT	Name		Relationship		Contact's Phone ( )	
NEW PATIENT?	☐ Yes ☐ No	General Dentist:	Referred by:		Email Address	

II. GUARANTOR/PARENT

NAME	Legal First Name	M.I.	Last Name		Birth date / /	
ADDRESS	Street			Apt #	Home Phone ( )	
	City		State	Zip	Cell Phone ( )	
EMPLOYED?	☐ Yes ☐ No | ☐ Full-time ☐ Part-time ☐ Retired				Social Security # - -	
EMPLOYER	Company		Address		Position	
	City		State	Zip	Work Phone ( )	

III. DENTAL INSURANCE

PRIMARY DENTAL					Insured Party	
ADDRESS	Street				Relation to Patient	
	City		State	Zip	Insured's Birthdate / /	
ID # / POLICY #		Group #			Insurance Co. Phone ( )	
INSURED'S ADDRESS	Street				Employer	
	City		State	Zip	Insured's Phone ( )	
SECONDARY DENTAL					Insured Party	
ADDRESS	Street				Relation to Patient	
	City		State	Zip	Insured's Birthdate / /	
ID # / POLICY #		Group #			Insurance Co. Phone ( )	
INSURED'S ADDRESS	Street				Employer	
	City		State	Zip	Insured's Phone ( )	

III. MEDICAL INSURANCE

PRIMARY MEDICAL					Insured Party	
ADDRESS	Street				Relation to Patient	
	City		State	Zip	Insured's Birthdate / /	
ID # / POLICY #		Group #			Insurance Co. Phone ( )	
INSURED'S ADDRESS	Street				Employer	
	City		State	Zip	Insured's Phone ( )	
SECONDARY MEDICAL					Insured Party	
ADDRESS	Street				Relation to Patient	
	City		State	Zip	Insured's Birthdate / /	
ID # / POLICY #		Group #			Insurance Co. Phone ( )	
INSURED'S ADDRESS	Street				Employer	
	City		State	Zip	Insured's Phone ( )	

STOP! PLEASE RETURN TO THE FRONT DESK BEFORE CONTINUING.

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Although as oral surgeons we primarily treat the area in and around your mouth, we need to review your overall general health. Any medical problems that you may have,or medications prescribed by other providers, can significantly affect the care we provide. We are required by law to maintain the privacy of your health information and will use it only in your treatment unless you authorize otherwise.

	Please answer the following questions "yes" or "no." If your answer to any questions is "yes," please provide details in the space provided below:	YES	NO
1.	Are you having surgery today?	☐	☐
	a. If yes, have you had anything to eat or drink in the last 8 hours, including gum, candy, or water?	☐	☐
	b. If yes, do you have someone to drive home & stay with you?	☐	☐
2.	Have you ever been pre-medicated with antibiotics prior to a dental procedure?	☐	☐
3.	Do you have any allergies to medications? PLEASE LIST	☐	☐
4.	Are you allergic to eggs or soy?	☐	☐
5.	Do you have any other food allergies?	☐	☐
6.	Do you have an artificial joint or implant in your hips, knees, shoulders, etc?	☐	☐
7.	Have you ever had complications from general anesthesia or dental treatment?	☐	☐
8.	Are you currently taking any medications prescribed by a doctor? _____ _____	☐	☐
9.	Do you have inflamed areas, growths, or sore spots in or around your mouth?	☐	☐
10.	Do you have any unhealed injuries?	☐	☐
11.	Are you being treated by a physician for any chronic medical problems?	☐	☐
12.	Have you ever been hospitalized?	☐	☐
13.	Do you have a cold or sore throat now?	☐	☐
14.	Do you have clicking, popping, or pain in your jaw joints?	☐	☐
15.	Do you have frequent or severe headaches?	☐	☐
16.	Do you have vision impairment or hearing loss?	☐	☐
17.	Has a physician told you that you have a heart murmur or heart disease?	☐	☐
18.	Have you had a heart attack?	☐	☐
19.	Have you had a heart valve repair or replacement?	☐	☐
20.	Are your ankles often swollen?	☐	☐
21.	Do you get short of breath, even without exertion?	☐	☐
	a. Asthma?	☐	☐
	b. Sleep apnea?	☐	☐
22.	Do you currently have a cough or chest congestion?	☐	☐
23.	Do you smoke or chew tobacco? Quantity: _____ Frequency: _____	☐	☐
24.	Do you have stomach or bowel problems?	☐	☐
25.	Do you any medications make you nauseated?	☐	☐
26.	Has a physician told you that you have a kidney disease?	☐	☐
27.	Are you frequently thirsty?	☐	☐
28.	Do you have a bleeding disorder or blood disease?	☐	☐
29.	Have you ever had severe bleeding after dental extractions or cuts?	☐	☐
30.	Do you take blood thinning medication such as Coumadin?	☐	☐
31.	Have you ever fainted?	☐	☐
32.	Have you ever had a seizure? Date of last seizure: _____	☐	☐
33.	Are you taking anti-seizure medications?	☐	☐
34.	Have you ever had radiation therapy or chemotherapy?	☐	☐
35.	Are you taking osteoporosis medications such as Fosamax, Boniva, or Aredia?	☐	☐
36.	Are you nursing?	☐	☐
37.	Is there a possibility you are pregnant? Estimated due date: _____	☐	☐
38.	Are you taking birth control pills, DepoProvera or using a patch?	☐	☐
39.	Do you take any medications for anxiety or sleeplessness?	☐	☐

Any other medical concerns:

_____
_____
_____
_____

Patient & Account #: _____

AGE & SEX Age: ☐ M ☐ F

HEIGHT/ WEIGHT Ht: Wt:

Are you wearing contacts? ☐ Yes ☐ No

Your medical doctor's name:

STAFF USE ONLY	BP	P	R	T

IMPORTANT INFORMATION

Medications used in routine oral surgery may interact with street / illicit drugs as well as prescription medications. These interactions can be *severe and may be life-threatening*.

It is extremely important that you inform your surgeon of any drug that you are using currently, or may have taken recently, so it can be taken into consideration in planning your oral surgery. We will keep your information in the strictest confidence, using it only to ensure your safe and appropriate surgical care.

PLEASE CHECK IF YOU HAVE EVER BEEN DIAGNOSED WITH:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hepatitis or Jaundice
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Immunosuppressive Conditions
- ☐ Latex Allergy
- ☐ Pneumonia
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Other: _____
- ☐ None of the above