COLORADO SPRINGS
ORAL & FACIAL SURGERY

Patient Information

Name: _____ Nickname: _____ Date:_____
Address: _____ City, State: _____ Zip Code: _____
Phone: _____ DOB: _____ Social Security #: _____Marital Status: _____
Employer: _____ Address: _____ Work Phone:_____
Emergency Contact: _____ Phone: _____ Relationship: _____
Whom may we thank for referring you?_____ Dentist: _____
Physician: _____ Purpose of visit:_____
Person responsible for bill: _____ DOB: _____ SSN: _____
Address: _____ City/State: _____ Zip: _____ Phone: _____
Dental Insurance Co: _____ Group #: _____ Policy #: _____
Address of Insurance: _____ City/State: _____ Zip: _____
Insurance Phone #: _____ Employer: _____
Name of Policy Holder: _____ DOB: _____ SSN: _____
***I authorize the release of medical/dental/other information necessary to process my bill or insurance claim. I authorize payment of medical/dental benefits to Colorado Springs Oral Surgery, PC.

Medical History

Age: ____ Weight:_____ Height: _____ Sex: _____ Conditions for which you have seen a doctor in the last 2 years: _____
Drug allergies (Penicillin, Sulfa, Codeine, etc): _____
Medications you are taking: _____
Serious illnesses: _____ Have you ever had a general anesthetic?_____
Complications with surgery/anesthesia:_____
Is there a possibility you could be pregnant?____ Due date:_____ Any jaw joint (TMJ) problems:_____
Do you smoke?_____ How many packs/day?_____ How many years?_____
Do you drink?_____ How many drinks/day?_____ How many years?_____

Do you have a history of, or are you suffering from any of the following?

Y N Previous stroke/TIA	Y N Heart trouble	Y N Chest pain
Y N High/low blood pressure	Y N Heart murmur	Y N Rheumatic Fever
Y N Diabetes	Y N Endocrine/Thyroid problem	Y N Sinus trouble
Y N Asthma	Y N Emphysema/Bronchitis	Y N Sleep Apnea
Y N Stomach Trouble	Y N AIDS/HIV	Y N Anemia
Y N Bleeding Disorder	Y N Treatment of Tumor/Cancer	Y N Kidney condition
Y N Liver condition	Y N Joint Replacement	Y N Epilepsy/Seizures
Y N Alcohol abuse	Y N Drug abuse	Y N Hepatitis
Y N Previous use of Fen-Phen	Y N Psych condition/Depression/Anxiety/Bipolar	

Y N Current or previous use of **Xgeva/Denosumab/Amgen** or **Avastin/Bevacizumab** (cancer chemo)
Y N Current or previous use of **Aredia/Pamidronate** or **Zometa/Zoledronate** (cancer chemo)
Y N Current or previous use of **Fosamax, Actonel, Reclast, Boniva, Didronel** or **Skelid** for osteoporosis

Signature of Patient or Parent/Guardian:_____ Reviewed by Dr. _____