STEEL CITY ORAL SURGERY

R.D. DACHILLE, D.M.D.
R.A. LAING, D.M.D.
T.R. PALADINO, D.D.S.

PATIENT HEALTH & INFORMATION

Date _____

Patient Social Security # _____

Patient Name _____
Last First Middle Date of Birth Sex Age

Marital Status _____ Spouse's Name _____
Single Married

Home Address _____
Number and Street City State Zip Code Contact Phone #

Height _____ Weight _____ Occupation _____

Employer _____
Name Address Employer's Telephone #

Closest Relative _____ Telephone # _____

Do you have **DENTAL** insurance? _____
Carrier ID Number or Social Security # Name of Subscriber and D.O.B.

MEDICAL insurance? _____
Carrier ID Number or Social Security # Name of Subscriber and D.O.B.

Person responsible for account _____
Name Address

Dentist _____
Name Address Telephone #

Physician _____
Name Address Telephone #

Reason for Appointment _____

Name of the doctor or other person who referred you to our office _____

1. Are you currently under the care of a physician? _____ Yes No

   If yes, what is the condition being treated? _____
2. Are you taking, or have you taken, any medications in the past 6 months? _____ Yes No

   Please list medications. _____
3. Have there been any changes in your health within the past year? _____ Yes No

   If yes, please explain. _____
4. Have you had any serious illness or operation? _____ Yes No
5. Do you have any limitation to daily activities? _____ Yes No
6. Do you have, or have you had, any of the following:

   a. Heart disease, heart attack, heart surgery/catheterization _____ Yes No

   b. Irregular heart beat or heart murmur _____ Yes No

   If yes, when? _____
7. Are you allergic to any medications? _____ Yes No

   Please list medications. _____
8. Do you smoke? _____ Yes No

   If yes, how many packs per day? _____

9. Do you have a history of any of the following:

   a. Lung disease (emphysema, bronchitis, or malignancy) _____ Yes No

   b. Thyroid disease _____ Yes No

   c. High blood pressure _____ Yes No

   d. Low blood pressure _____ Yes No

   e. Epilepsy or fainting spells _____ Yes No

   f. Diabetes _____ Yes No

   g. Arthritis _____ Yes No

   h. Stomach ulcers or other disease of the intestine _____ Yes No

   i. Kidney disease _____ Yes No

   j. Glaucoma _____ Yes No

   k. Hepatitis _____ Yes No

   l. Venereal disease _____ Yes No

   m. A.I.D.S. (Acquired Immune Deficiency Syndrome) _____ Yes No

   n. Have you ever been tested for A.I.D.S.? _____ Yes No

10. Are you wearing contact lenses? _____ Yes No

11. Have you had abnormal bleeding associated with previous extractions or surgery? _____ Yes No

12. Do you have any blood disorders? _____ Yes No

13. Have you ever had a blood transfusion? _____ Yes No

14. Have you ever had surgery or x-ray treatment for a tumor growth of your face, neck, or mouth? _____ Yes No

15. Have you ever had a general anesthetic (gone to sleep for surgery)? _____ Yes No

16. Do you have any disease, condition, or problem you think we should know about? _____ Yes No

17. Women:

   a. Are you pregnant? _____ Yes No

   b. Are you taking birth control pills? _____ Yes No

      ** If yes, please be advised that antibiotics may decrease their effectiveness.

18. Men:

   a. Are you taking any erectile dysfunction medications? _____ Yes No

I HEREBY CONSENT TO THE EXAMINATION, CONSULTATION, AND TREATMENT, INCLUDING THE ADMINISTRATION OF ANESTHETICS, BY DR. DACHILLE / DR. LAING / DR. PALADINO, AND BY ANY PROFESSIONAL OR ASSISTANT AS HE MAY DEEM NECESSARY DURING THE COURSE OF MY TREATMENT. I ACKNOWLEDGE THAT I HAVE BEEN FULLY INFORMED ABOUT MY TREATMENT BY DR. DACHILLE / DR. LAING / DR. PALADINO INCLUDING ALTERNATIVE TREATMENTS, RISKS, AND COMPLICATIONS, WHEN INDICATED, AND THAT I UNDERSTAND THEM.

Witness _____ Signature of patient, parent, or legal guardian _____

_____

R.D. DACHILLE, D.M.D. / R.A. LAING, D.M.D. / T.R. PALADINO, D.D.S