Perry B. Young, D.D.S., LTD.
Diplomate American Board of
Oral & Maxillofacial Surgery

PATIENT INFORMATION FORM

PATIENT INFORMATION

DATE	LAST NAME	FIRST NAME	M.I.	PATIENT GOES BY
ADDRESS				
CITY		STATE/ZIP		
HOME PHONE	WORK PHONE	EXT.	CELL PHONE	
SEX ❑ MALE ❑ FEMALE	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED			
BIRTH DATE	AGE	SOC. SEC. – –		
EMAIL		FAMILY DENTIST		
IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT AT OUR OFFICE?				
family member's name		relationship		
EMERGENCY CONTACT (NAME)		EMERGENCY CONTACT (PHONE NUMBER)		
PATIENT IS ❑ POLICY HOLDER ❑ RESPONSIBLE PARTY ❑ NEITHER				

FINANCIALLY RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)

LAST NAME	FIRST NAME	M.I.
ADDRESS		
CITY	STATE/ZIP	
HOME PHONE	WORK PHONE EXT.	CELL PHONE
BIRTH DATE	SOC. SEC. – –	
NAME OF EMPLOYER	WORK ADDRESS	WORK PHONE
❑ RESPONSIBLE PARTY IS ALSO A POLICY HOLDER FOR PATIENT ❑ PRIMARY INSURANCE POLICY HOLDER ❑ SECONDARY INSURANCE POLICY HOLDER		

PRIMARY INSURANCE INFORMATION

LAST NAME OF INSURED	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT	
INSURED SOC. SEC. – –			INSURED BIRTH DATE	
ADDRESS OF INSURED			INS. COMPANY	PHONE
CITY/STATE/ZIP			ADDRESS	
PHONE			CITY/STATE/ZIP	
NAME OF EMPLOYER	PHONE		I.D. #	GRP #

SECONDARY INSURANCE INFORMATION

LAST NAME OF INSURED	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT	
INSURED SOC. SEC. – –			INSURED BIRTH DATE	
ADDRESS OF INSURED			INS. COMPANY	PHONE
CITY/STATE/ZIP			ADDRESS	
PHONE			CITY/STATE/ZIP	
NAME OF EMPLOYER	PHONE		I.D. #	GRP #

MEDICAL HISTORY

Answers to the following questions are for our records only and will be considered confidential.

What is the reason for this visit? _____

1. Check any of the following which you have had or have at present:

❑ Heart Failure	❑ Kidney Trouble	❑ X-ray Treatment	❑ Blood Transfusion
❑ Heart Disease or Attack	❑ Ulcers	❑ Chemotherapy (Cancer, Leukemia)	❑ Venereal Disease
❑ Angina Pectoris	❑ Emphysema	❑ Rheumatism	(Syphilis, Gonorrhea)
❑ High Blood Pressure	❑ Cough	❑ AIDS (HIV positive)	❑ Cold Sores or Herpes
❑ Stroke	❑ Tuberculosis	❑ Drug Addiction	❑ Epilepsy or Seizures
❑ Mitro Valve Prolapse	❑ Asthma	❑ Alcoholism	❑ Nervousness
❑ Congenital Heart Lesions	❑ Sinus Trouble	❑ Hepatitis A (Infectious)	❑ Psychiatric Treatment
❑ artificial h eart Valve	❑ Diabetes	❑ Hepatitis B (Serum)	❑ Liver Disease
❑ Heart Pacemaker	❑ Thyroid Disease	❑ Hepatitis (Non AB)	❑ Artif. Joint (Knee, Hip, etc)
❑ Heart Surgery			

2. Are you now under the care of a physician? _____ ❑ Yes ❑ No
   If so, what is the condition being treated? _____
   _____
3. Have you had any serious illness or operation not listed above? ❑ Yes ❑ No
   If so, what was the illness or operation?
4. Who was the operating surgeon? _____
5. Do you require any premedication with antibiotics prior to any dental treatment? ❑ Yes ❑ No
6. Do you have any popping/clicking or pain in your jaw joints? _____ ❑ Yes ❑ No
   If so, for how long? _____
7. Have your jaws ever locked open or closed? ❑ Yes ❑ No
8. Have you had abnormal bleeding associated with any previous extraction, surgery, or trauma? ❑ Yes ❑ No
9. Have you taken any diet medication in the last month? ❑ Yes ❑ No
10. Do you have any respiratory or lung problems? ❑ Yes ❑ No
11. Do you have asthma? ❑ Yes ❑ No
    If so, when was your last attack? _____ Last date hospitalized with asthma?
    Do you use an inhaler? ❑ Yes ❑ No Name of inhaler _____
12. Do you smoke? ❑ Yes ❑ No
13. Have you had surgery, medication or radiation treatment for a tumor, growth or other condition of your head or neck? ❑ Yes ❑ No
14. Are you taking any drug or medicine? _____ ❑ Yes ❑ No
    Please list: _____
    _____
    _____
    _____
15. Are you allergic or have you reacted to the following? what was your reaction? (Please list next to medicaction).

a. Local anesthetic ❑ Yes ❑ No		f. Barbituates, sedatives, or sleeping pills ❑ Yes ❑ No	
b. Penicillin ❑ Yes ❑ No		g. Aspirin ❑ Yes ❑ No	
c. Other antibiotics ❑ Yes ❑ No		h. Iodine ❑ Yes ❑ No	
(List name) _____		i. Codeine or other narcotics ❑ Yes ❑ No	
d. Sulfa drugs ❑ Yes ❑ No		j. Other: _____	
e. Ibuprofen (Advil, Motrin) ❑ Yes ❑ No		(Comments: _____)	

16. Have your or has anyone in your family ever been advised of any complications during any anesthetic? (Malignant hyperthermia) ❑ Yes ❑ No
17. Have you had anything to EAT or DRINK within the last 8 hours? ❑ Yes ❑ No
18. WOMEN:
    a. Are you pregnant? ❑ Yes ❑ No
    b. Are you using a hormonal means of birth control (pills, injections, implants)? ❑ Yes ❑ No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform Dr. Young at the next appointment without fail.

_____

DATE SIGNATURE OF PATIENT, PARENT OR GUARDIAN

UPDATE: Date: _____ Initials: _____ UPDATE: Date: _____ Initials: _____