

MICHAEL M. BIANCO, D.M.D.

Oral and Maxillofacial Surgery

Patient's Name _____
Last First Middle

Address _____
City State Zip Code

Occupation _____ Soc. Sec. # _____
 Employer _____

Business Address _____
City State Zip Code

Business Phone _____

Age _____ Sex _____ Date of Birth _____

Residence Phone _____

Patient's Dentist _____

Patient's Physician _____

Referred by _____

Insurance Co. _____

Subscriber _____

Group Number _____

Agreement Number _____

Plan _____

FINANCIALLY RESPONSIBLE PARTY: (IF OTHER THAN ABOVE) **SS#**
DOB

Name _____
Last First Middle

Address _____
City State Zip Code

Business Address _____
City State Zip Code

Relationship to Patient _____

Residence Phone _____

Employer _____

Business Phone _____

Occupation _____

Have you had any of the following: (X the appropriate box)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease (Congenial Heart Disease, Heart Attack,	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Failure)	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Disease
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain (Angina)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath on Exertion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (Hepatitis, Cirrhosis, Jaundice)
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	Anemia (Sickle Cell, Iron Deficiency)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Any Joint Replacement (Hip, Knee, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease (TB, Emphysema, Pneumonia)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Therapy

Please answer each question:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you been hospitalized or had any recent surgery in the past 5 years?
Describe . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been under the care of a physician during the past 2 years?
Describe . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you taken any medication or drugs during the past 2 years?
Please list the drugs. . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you allergic to penicillin, novacaine or any other medication?
Describe . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had prolonged bleeding after minor cuts, tooth extraction or surgery?
Describe . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had any radiation (x-ray) treatment ?
Describe . . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Please inform the doctor of any serious illness or disease you have not listed . . . | | |
| 9. Please list your dentist and any recent dental problems . . . | | |

Signature of Patient, Parent, Guardian _____

Date _____