Donald A. DeCino, D.D.S., P.C.

Oral and Maxillofacial Surgery

Please Print

Patient's Name ____________________ Marital Status ________ Age ______ Birthdate __________
Last First Middle

Patient's Address ______________________________ Home Phone ______________

City ____________________ State ______ ZIP __________ Cell Phone ______________

Social Sec. # ________-________-________ e-mail address ______________

Employer ______________ Occupation ______________ Work Phone ______________

Dental Ins. ______________________ Medical Ins. ______________________

Secondary Dental Ins. ______________________ Secondary Medical Ins. ______________________

Parent / Spouse Name ______________________ Address ______________________

INSURANCE POLICY HOLDER'S INFORMATION

Name ______________ Home Phone ______________ Cell Phone ______________

Address ______________________ State ________ Zip Code ______________

Social Sec. # ________-________-________ Insured's Date of Birth __________ e-mail address ______________

Employer ______________ Address ______________ Work Phone ______________

Nearest Relative ______________________ Address ______________________

Patient's General Dentist ______________________ Orthodontist ______________________

Referred By ______________________ Reason you wish to see the doctor ______________________

MEDICAL HISTORY

******PLEASE ANSWER BY CIRCLING Yes(Y) or No(N) FOR EACH INDIVIDUAL QUESTION.**

1. Have you or a family member been a patient here before?.................................... Y N
2. Have you been under the care of a physician during the last 2 years?.................... Y N
   If so, what for? ______________________________
   ____

Treatment physician's name? ______________________ Telephone number ______________
Address: ______________________________

3. Date of your last Physical Examination by a physician ______________
4. Have you ever had any operations, hospitalizations or serious illness?.................... Y N
   If so, describe and give approximate dates ______________________________
   ____
   ____
   ____
   ____
   ____
   ____

▶ **Please continue on the other side**

5. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for cancer (Reclast, Fosomax, Actonel, Boniva, Aredia or Zometa)? .... Y N

6. Are you taking or using any of the following:

- A. Stomach or GI medications........ Y N
- B. Thyroid Medications........ Y N
- C. Antibiotics?........ Y N
- D. Anticoagulants (Blood thinners)?........ Y N
- E. High blood pressure medicine?........ Y N
- F. Steroids?........ Y N
- G. Tranquilizers, Antidepressants?........ Y N
- H. Insulin or Oral Anti-Diabetic drugs?........ Y N
- I. Aspirin, Ibuprofen, Aleve?........ Y N
- J. Antihistamines or decongestants?........ Y N
- K. Heart Medications?........ Y N
- L. Cholesterol reducing medication?........ Y N
- M. Narcotics, opioids, or other pain relievers?........ Y N
- N. Marijuana, cocaine or other "recreational" drugs?... Y N
- O. Weight reduction pills or diet aids?........ Y N
- P. Any other regular medicines, pills or supplements?........ Y N

7. Are you Allergic to:

- A. Local Anesthesia?........ Y N
- B. Penicillin, Amoxicillin, or other antibiotics?........ Y N
- C. Barbiturates, sedatives........ Y N
- D. Aspirin or Ibuprofen........ Y N
- E. Codeine of pain killers?........ Y N
- F. Latex or Rubber products?........ Y N
- G. Other Allergies or reactions?........ Y N

  Please list ____________________

8. Do you smoke........ Y N

How much per day ________ ,For how long ________

9. Do you use oral tobacco?........ Y N

10. Do you use alcohol? How much?........ Y N

11. Do you have or have you ever had:

- A. Rheumatic heart disease of Rheumatic fever?..... Y N
- B. Heart Trouble (heart attack, chest pain)?........ Y N

  Date of heart attack ____________________
- C. Artificial heart Valves?........ Y N
- D. Heart Murmer?........ Y N
- E. Hypertension (High Blood Pressure)?........ Y N
- F. Asthma?........ Y N
- G. Other Lung disease (tuberculosis, emphysema, Bronchitis, pneumonia)?........ Y N
- H. Seizures, epilepsy, fainting spells?........ Y N
- I. Stroke, TIA, Mini-Stroke........ Y N

  Date: ____________________
- J. Bleeding Disorders, anemia, bruise easily?........ Y N
- K. Liver disease (Jaundice, Hepatitis)?........ Y N
- L. Kidney disease?........ Y N
- M. Diabetes?........ Y N
- N. Thyroid Disease?........ Y N
- O. Arthritis?........ Y N
- P. Glaucoma?........ Y N
- Q. Implants/artificial joints anywhere in your Body (heart valve, knee, hip, etc.)........ Y N

  Date of placement ____________________
- R. Radiation therapy for cancer........ Y N
- S. Noises or pain in jaw joint when chewing?........ Y N
- T. Do you grind or clench teeth?........ Y N
- U. Chemotherapy?........ Y N
- V. Any disease, drug or transplant operation that has depressed your immune system........ Y N
- W. Sinus or nasal problems?........ Y N

For Women Only

A. Are you or do you think you may be pregnant........ Y N

B. If you are pregnant, possibly pregnant or trying to become pregnant, surgery, anesthesia or any other medication may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any chance of your being pregnant.

C. If you are using oral contraceptives it is important that you understand that Antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications if completed. ________ Initials

I understand the importance of an accurate health history and to the best of my knowledge the above information is true.

Signature of person completing health history ________ date ________ Doctor's Initials ________

Medical History Update:

Date	Comments	Patient Signature

Current Medications:

Medication	Dose	Time of day taken			Prescribing Doctor
		AM	Mid-Day	PM	

FOR OFFICE USE ONLY:

ALLERGIES: ______________________________

MEDICAL HISTORY ADDENDUM:

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