CENTRAL ARKANSAS

ORAL & MAXILLOFACIAL SURGERY CENTER

Steven F. Molpus, DDS, PLC
William Alfonso, DDS
Jeffrey Brooks, DMD

DOCTOR YOU ARE SEEING TODAY: ☐ DR. MOLPUS ☐ DR. ALFONSO ☐ DR. BROOKS ☐ MARRIED AGE _____

PATIENT NAME & ADDRESS _____ (LAST) _____ (FIRST) _____ (MIDDLE INITIAL) ☐ SINGLE SEX: M F

_____ ☐ DIVORCED DATE OF BIRTH _____

_____ (CITY) _____ (STATE) _____ (ZIP) ☐ WIDOWED WEIGHT _____

HOME PHONE _____ SOCIAL SECURITY/DL # _____ CELL # _____

EMPLOYED BY _____ OCCUPATION _____ BUSINESS PHONE _____

NAME OF: ORTHODONTIST _____ DENTIST _____ PHYSICIAN _____

IF MINOR, PATIENT'S GUARDIAN/PARENT _____ PH. # _____

ADDRESS _____ CITY / STATE / ZIP CODE _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU) NAME / RELATIONSHIP _____ PHONE _____

REASON FOR THIS APPT.: _____

WHO REFERRED YOU? _____

PLEASE ANSWER ALL QUESTIONS — CIRCLE

1. Allergic to ANY medicines? What? _____ NO YES
2. Under the care of Physician? Why? _____ NO YES

   _____
3. Taking any medicines? What? _____ NO YES
4. Do you now take, or have you in the past taken Fosamax or Steroids (Cortisone) _____ NO YES
5. Have you had any illness, operation, or been hospitalized in the past five years? _____ NO YES
6. Have you ever been put to sleep? _____ NO YES

   If yes, did you have problems with the anesthesia? _____ NO YES
7. Do you now have a sore throat or cold? _____ NO YES
8. Tobacco Use - Type? _____ How long? _____ How much daily? _____ NO YES
9. Have you had: (Circle)

High Blood Pressure	Blood Thinners	Sinus Disease	Other Serious Illness
Low Blood Pressure	Diabetes	Pain or Clicking of Jaws	
Stroke	Asthma	Sleeping or Snoring Problems	
Heart Attack	Shortness of Breath	Radiation Treatment	
Pacemaker	Lung Disease	Glaucoma	
Heart Disease	Ulcers (Stomach)	Epilepsy	
Heart MurMur (MVP)	Anemia	Kidney Condition	
Chest Pains	Blood Disease	Jaundice or Hepatitis	
Rheumatic Fever	Bleeding Problems	Psychiatric or Chemical Dependency Care	
Arthritis	Thyroid Trouble	Problems with Immune System	
Cancer/Tumors	Artificial Joints/Valves		

10. Do you wear contact lens? _____ NO YES
11. (Women) Are you pregnant now? _____ How many months? _____ NO YES
12. Are you taking birth control pills? _____ NO YES

Signature _____ Date _____