



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 CITY STATE ZIP
[ ] SINGLE SEX: M F
[ ] DIVORCED DATE OF BIRTH \_\_\_\_\_
[ ] 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 \_\_\_\_\_