MICHAEL M. BIANCO, D.M.D.
Oral and Maxillofacial Surgery

Patient's Name ______ (Last / First / Middle) ______ Age ______ Sex ______ Date of Birth ______

Address ______

______ City / State / Zip Code

Occupation ______ Soc. Sec. # ______

Employer ______

Business Address ______

______ City / State / Zip Code

Business Phone ______

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	
☐	☐	Rheumatic Fever	☐	☐	Heart Valve Replacement
☐	☐	Heart Disease (Congenial Heart Disease, Heart Attack,	☐	☐	Asthma
☐	☐	Congestive Failure)	☐	☐	Hay Fever
☐	☐	Heart Murmur	☐	☐	Sinus Disease
☐	☐	Chest Pain (Angina)	☐	☐	Diabetes
☐	☐	Shortness of Breath on Exertion	☐	☐	Kidney Disease
☐	☐	Difficulty Breathing Lying Down	☐	☐	Liver Disease (Hepatitis, Cirrhosis, Jaundice)
☐	☐	Swollen Ankles	☐	☐	Venereal Disease
☐	☐	High Blood Pressure (Hypertension)	☐	☐	Anemia (Sickle Cell, Iron Deficiency)
☐	☐	Stroke	☐	☐	Arthritis
☐	☐	Fainting	☐	☐	Any Joint Replacement (Hip, Knee, etc.)
☐	☐	Lung Disease (TB, Emphysema, Pneumonia)	☐	☐	Thyroid Disease
☐	☐	Persistent Cough	☐	☐	Epilepsy
☐	☐	HIV Positive	☐	☐	Cancer
☐	☐	Mitral Valve Prolapse	☐	☐	Psychiatric Therapy

Please answer each question:

	Yes	No
1. Have you been hospitalized or had any recent surgery in the past 5 years? Describe . . .	☐	☐
2. Have you been under the care of a physician during the past 2 years? Describe . . .	☐	☐
3. Have you taken any medication or drugs during the past 2 years? Please list the drugs. . .	☐	☐
4. Are you allergic to penicillin, novacaine or any other medication? Describe . . .	☐	☐
5. Have you ever had prolonged bleeding after minor cuts, tooth extraction or surgery? Describe . . .	☐	☐
6. Are you pregnant?	☐	☐
7. Have you ever had any radiation (x-ray) treatment ? Describe . . .	☐	☐

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