cherry creek ORAL SURGERY

John R. Nesiba, M.D., D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Diplomate, American Board of Facial Cosmetic Surgery

Date ____/____/____

Patient's Name _____ Age _____ Date of Birth ____/____/____
Last First Middle

Patient's SS# ____-____-____ Sex ____Male ____Female Height ____ft ____in Weight ____lbs ____kg

Patient's Address _____ City _____ County _____ State _____ Zip _____

Home Phone # (____) ____-____ Business Phone # (____) ____-____ Cell # (____) ____-____

Patient's Employer _____ Business Address _____ Patient's Occupation _____

Person not living with you whom we can contact in case of emergency: _____ **Phone # (____)** ____-____

Who is your Family Physician _____ Address _____ Phone # (____) ____-____

Who is your Family Dentist _____ Address _____ Phone # (____) ____-____

Referred by _____ Address _____ Phone # (____) ____-____

If under age 18, who is responsible for paying your account? (Guarantor) ( ) Self ( ) Spouse ( ) Father ( ) Mother ( ) Other _____

Guarantor's Name _____ SS# ____-____-____
Last First Middle

Guarantor's Address _____ City _____ County _____ State _____ Zip _____

Phone # (____) ____-____ Cell# (____) ____-____ Date of Birth ____/____/____ Sex ____Male ____Female

Marital Status:( ) Single ( ) Married: Spouse's Name _____ ( ) Widowed ( ) Divorced
Last First Middle

Employer _____ Address _____ Phone # (____) ____-____

Guarantor's Occupation _____ ( ) Full Time ( ) Part Time ( ) Retired

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INSURANCE INFORMATION

PATIENT: Student: ( ) Full Time ( ) Part Time ( ) Not School Name/City/State _____

( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Legally Separated _____

Employed: ( ) Full Time ( ) Part Time ( ) Retired ( ) Not Do you belong to a PPO or HMO? ( ) Yes ( ) No

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PRIMARY DENTAL INSURANCE

Name _____

Address _____

_____

Phone # (____) ____-____

Does your plan cover: ( ) Medical ( ) Dental ( ) Both

Group # _____ Group Name _____

_____

POLICY HOLDER

Name _____

Your relation to insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Gender: ( ) Male ( ) Female Date of Birth ____/____/____

Street _____

City _____ State _____ Zip _____

Phone # (____) ____-____

SS# ____-____-____ ID# _____

Is this an Employer Health Insurance Plan? ( ) No ( ) Yes Employer Name _____

Phone # (____) ____-____ Street _____ City _____ State _____ Zip _____

SECONDARY INSURANCE / MEDICAL INSURANCE

Name _____

Address _____

_____

Phone # (____) ____-____

Does your plan cover: ( ) Medical ( ) Dental ( ) Both

Group # _____ Group Name _____

_____

POLICY HOLDER

Name _____

Your relation to insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Gender: ( ) Male ( ) Female Date of Birth ____/____/____

Street _____

City _____ State _____ Zip _____

Phone # (____) ____-____

SS# ____-____-____ ID# _____

Is this an Employer Health Insurance Plan? ( ) No ( ) Yes Employer Name _____

Phone # (____) ____-____ Street _____ City _____ State _____ Zip _____

Is this visit related to an accident? Auto: ( ) Yes ( ) No Work Related: ( ) Yes ( ) No Other: _____

Date of injury: ____/____/____ Insurance Co. handling this claim: _____ Claim #: _____

Name of Attorney / Adjuster: _____ Phone # (____) ____-____

Attorney / Adjustor's Address _____ City _____ County _____ State _____ Zip _____

CONFIDENTIAL INFORMATION

Staff use only: _____ Date: ____/____/____

Please describe your main symptom or problem (reason for today's visit): _____

Date of last physical ____/____/____ Are you now, or have you been in the last five years, under the care of a physician for a specific problem? ( ) Yes ( ) No If yes, describe _____

PAST MEDICAL HISTORY

Have you had or do you currently have (please check "Yes" or "No" to each question individually):

Yes	No		DETAILS/YEAR
( )	( )	Abnormal **Bleeding** or bruise easily?	
( )	( )	Blood disorder such as **Anemia**?	
( )	( )	Blood transfusion?	
( )	( )	Glaucoma / Eye disease?	
( )	( )	**Seizures** / Epilepsy?	
( )	( )	**Stroke**?	
( )	( )	Dizzy spells?	
( )	( )	**Heart disease**?	
( )	( )	Chest pain? How often?	
( )	( )	Rheumatic Fever?	
( )	( )	Heart murmur?	
( )	( )	High blood pressure?	
( )	( )	Low blood pressure?	
( )	( )	Heart attack(s)? When?	
( )	( )	Irregular heart beat?	
( )	( )	**Pacemaker**?	
( )	( )	Implanted defibrillator?	
( )	( )	Heart stent?	
( )	( )	Open heart surgery?	
( )	( )	Vascular graft?	
( )	( )	**Prosthetic heart valve**?	
( )	( )	Swollen ankles?	
( )	( )	**Lung** problems?	
( )	( )	Asthma/Emphysema/COPD?	
( )	( )	Hospitalized for asthma? When?	
( )	( )	Recent pneumonia?	
( )	( )	Bronchitis / chronic cough?	
( )	( )	**Obstructive Sleep Apnea**?	
( )	( )	**CPAP/BiPAP**? Setting?	
( )	( )	Difficulty breathing?	
( )	( )	Do you smoke? ____packs per day for ____ years	
( )	( )	If you don't smoke now, have you ever smoked? If yes, ____packs per day for ____years. When did you quit?____	

Yes	No		DETAILS/YEAR
( )	( )	**Sinus** problems (infections)?	
( )	( )	**Kidney** problems or on dialysis?	
( )	( )	**Liver** problems?	
( )	( )	Jaundice (Yellow skin)?	
( )	( )	Hepatitis? (Circle) A B C	
( )	( )	Stomach ulcers?	
( )	( )	Infectious mononucleosis?	
( )	( )	Hypoglycemia (Low blood sugar)?	
( )	( )	**Diabetes**?	
( )	( )	Take Insulin?	
( )	( )	Taken prednisone/cortisone pills?	
( )	( )	**Thyroid** problems?	
( )	( )	Fibromyalgia?	
( )	( )	Disorder(s) of the immune system?	
( )	( )	Arthritis or joint disease?	
( )	( )	A **prosthetic joint**? Where?	
( )	( )	Muscular, spinal or neurologic disorders?	
( )	( )	Contagious diseases?	
( )	( )	Sexually-transmitted diseases?	
( )	( )	History of drug or alcohol abuse?	
( )	( )	Delay in healing?	
( )	( )	Tumor/growth/cancer?	
( )	( )	X-ray treatment to the head and/or neck for cancer? Total Dose: _____cGy. No. of treatments _____ Over what time span?	
( )	( )	**Chemotherapy**? When?	
( )	( )	Contact lens? **Please remove them before surgery!**	
( )	( )	Mental health problems?	
( )	( )	Had psychiatric care?	
( )	( )	Developmental delay?	
( )	( )	Pain or clicking in the jaws when eating?	
( )	( )	**Anesthesia problems?**	
( )	( )	**Malignant Hyperthermia?**	

PAST SURGICAL HISTORY

Please list your past surgeries (including oral surgery), starting with the most recent:

Date	Procedure	Anesthesia type (circle one)			Anesthesia Complications (check "none" if none)	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	
		General	Local	Sedation	( ) None	

Others: _____

Is there any condition concerning your health about which the doctor should be told? ( ) Yes ( ) No If yes, describe: _____

FAMILY HISTORY

Do you have a family history of the following? If yes, please tell us which relative(s).

Yes	No		Relative(s)	Yes	No		Relative(s)
( )	( )	Anesthesia problems		( )	( )	Diabetes	
( )	( )	Malignant hyperthermia		( )	( )	Heart disease	
( )	( )	Cancer				Other:	

WOMEN

Are you:

Yes	No		
( )	( )	**Pregnant**?	If yes, delivery date? _____/_____/_____ If you might be pregnant, but are not sure, please check here: ( )
( )	( )	**Nursing**?	If yes, please know that anesthesia medicines are found in breast milk following an anesthetic and can sedate your child. You should use alternative methods for nourishment for you child for 48 hours after an anesthetic and should pump and discard your breast milk during that time.
( )	( )	**Taking birth control pills**?	If yes, antibiotics that we prescribe may alter the effectiveness of birth control pills, such that you can get pregnant while taking the antibiotic. This possibility will be in effect for the remainder of your menstrual cycle. You should consult with your physician / OB-GYN for assistance regarding additional methods of birth control.

Please sign your initials to indicate your understanding: _____

ALLERGIES

Are you allergic to or have you had a reaction to any of the following medicines or substances? If yes, describe the reaction.

Yes	No		Reaction	Yes	No		Reaction
( )	( )	Local anesthetics ("Novocaine")		( )	( )	Thiopental (Pentothal)	
( )	( )	Penicillin		( )	( )	Aspirin (ASA)	
( )	( )	Amoxicillin		( )	( )	Ibuprofen (Advil, Motrin)	
( )	( )	Clindamycin (Cleocin)		( )	( )	Acetominophen (Tylenol, APAP)	
( )	( )	Cephalosporins (Keflex, Ceclor)		( )	( )	Narcotics	
( )	( )	Erythromycin		( )	( )	Codeine	
		Other antibiotics? List and describe:				**Other medications? List and describe:**	
( )	( )			( )	( )		
( )	( )			( )	( )		
( )	( )	Diazepam (Valium)		( )	( )		
( )	( )	Fentanyl (Sublimaze)		( )	( )	Pork	
( )	( )	Midazolam (Versed)		( )	( )	Eggs	
( )	( )	Methohexital (Brevital)		( )	( )	Latex / Rubber	
( )	( )	Propofol (Diprivan)		( )	( )	Adhesive Tape	

Allergies other than drug allergies (please list and describe reaction): _____

MEDICATIONS

There are some specific medicines that we need to know if you are taking:

Do you take **Anticoagulants / Blood thinners**? ( ) Yes ( ) No If yes, please circle which medicine:

Aggrenox (Dipyridamole) **Coumadin** (Warfarin) **Heparin** **Lovenox** (Enoxaparin) **Plavix** (Clopidogrel) **Pradaxa** (Dabigatran)

Do you take **aspirin**? ( ) Yes ( ) No How much and how often? _____ mg _____ Last dose _____

Do you take / have you ever taken an **oral bisphosphonate** medicine? ( ) Yes ( ) No If yes, please circle which medicine:

Actonel (Risedronate) **Boniva** (Ibandronate) **Didronel** (Etidronate) **Fosamax** (Alendronate) **Skelid** (Tiludronate)

How often? _____ How long? _____Years _____Months

Do you take / have you ever taken an **intravenous bisphosphonate** medicine? ( ) Yes ( ) No If yes, please circle which medicine:

Aredia (Pamidronate) **Bonefos** (Clodronate) **Boniva** (Ibandronate) **Reclast** (Zolendronate) **Zometa** (Zolendronate)

How often? _____ How long? _____Years _____Months

Patient Last Name _____ First Name _____ Middle _____ Today's Date ____/____/____

MEDICATION LIST

Including those listed on the previous page, do you take any kind of medicine, drugs, diet supplements, herbal remedies, or pills? ( ) Yes ( ) No

If no, please write "None" on the table below.

If yes, please list on the table below. See examples at the bottom of the table. Please fill in all information.

From what pharmacy do you obtain your prescription medicines? _____ Telephone: (____) _____-_____

Please list all the medicines you are taking and provide the following information (you can find this information on the bottle):

Name of Medicine	Date Started	Dose (mg)	Route (Oral / IV / Topical / Nasal)	Frequency / Directions on bottle	Reason for taking
Example: **None**					
Example: **Metoprolol / Lopressor**	**O1/O1/2009**	**25 mg**	**Oral**	**Twice a day**	**Hypertension (high BP)**
Example: **Gentamycin**	**O1/O1/2009**	**100 mg**	**Topical - Eyedrops**	**Once a day**	**Pinkeye**

Please bring all of your medicine bottles to your appointment.

I certify that I fully read and understand English, and I understand the questions and statements on this medical history form, and I have answered them truthfully.

My signature authorizes release of information to process my claim and to other health care providers about my history, examination, diagnosis, and treatment course.

_____ ____/____/____
Patient Signature **Date**

_____ ____/____/____
Parent or Guardian (if minor or developmentally-delayed) or Language Interpreter Signature **Date**

_____ ____/____/____
Surgeon **Date**