

# ASSOCIATED ORAL SURGEONS, INC.

CARROLLTON, TEXAS  
(972) 394-2114

FLOWER MOUND, TEXAS  
(972) 539-1491

## PATIENT INFORMATION:

Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
Apt # \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
SSN \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Spouse's Name \_\_\_\_\_

DATE: \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Suite # \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_  
Student? \_\_\_\_\_ Where? \_\_\_\_\_  
What Year? \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Sex \_\_\_\_\_  
Height \_\_\_\_\_  
Weight \_\_\_\_\_

## RESPONSIBLE PARTY (THE INSURED'S) INFORMATION:

Relation to Patient \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
Apt # \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex \_\_\_\_\_

SSN \_\_\_\_\_  
Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Suite # \_\_\_\_\_  
City \_\_\_\_\_  
State, Zip \_\_\_\_\_  
Work Phone (\_\_\_\_) \_\_\_\_\_  
Work Fax (\_\_\_\_) \_\_\_\_\_  
Drivers License # \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Spouse's Name \_\_\_\_\_

Dental Insurance Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_  
Policy # \_\_\_\_\_  
Medical Insurance Name \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

Insured's Name \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # \_\_\_\_\_

## HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN OUR PRACTICE?

No \_\_\_ Yes \_\_\_ Name of that person \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

NAME OF FAMILY DENTIST \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

**HEALTH QUESTIONNAIRE: Please complete thoroughly and as accurately as possible.**

GENERAL HEALTH (Please Check One): EXCELLENT , GOOD , FAIR , POOR .

Physician's Name: \_\_\_\_\_ Last complete physical: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:**

	YES	NO	WHEN		YES	NO	WHEN
Very High Fever with Disease as a Child	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hip, Knee or any joint prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain (Angina)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Damage	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Replacement (Prosthesis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High _____ or Low _____ Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Urinating Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis or other Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constant Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
High _____ or Low _____ Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Immune System Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Faint Easily	<input type="checkbox"/>	<input type="checkbox"/>	_____	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic Disease or Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any medical problem not on this questionnaire \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_, No \_\_\_\_\_, Packs per day? \_\_\_\_\_ Use Alcohol? Yes \_\_\_\_\_, No \_\_\_\_\_, How much per day? \_\_\_\_\_, Week \_\_\_\_\_

Do you now or have you ever used tranquilizers? Yes \_\_\_\_\_, No \_\_\_\_\_, When? \_\_\_\_\_, Why? \_\_\_\_\_

Are you now or have you ever been treated with cortisone or steroid drugs? Yes \_\_\_\_\_, No \_\_\_\_\_, When? \_\_\_\_\_

Why? \_\_\_\_\_

Have you ever been treated in the hospital, or had any surgery either in hospital or in Doctor's office or clinic? Yes \_\_\_\_\_, No \_\_\_\_\_, When? \_\_\_\_\_

Why? \_\_\_\_\_

Have you ever been treated (other than diagnosis) with X-Ray? Yes \_\_\_\_\_, No \_\_\_\_\_, When? \_\_\_\_\_

Are you allergic to: Penicillin \_\_\_\_\_, Codeine \_\_\_\_\_, Local Anesthetics \_\_\_\_\_, Demerol \_\_\_\_\_, Valium \_\_\_\_\_, Sodium Pentothal \_\_\_\_\_, Aspirin \_\_\_\_\_

Any other medication allergies: \_\_\_\_\_

Pregnant? Yes \_\_\_\_\_, No \_\_\_\_\_, How Long? \_\_\_\_\_, Periods: Normal \_\_\_\_\_, Abnormal \_\_\_\_\_, Date of Last Period \_\_\_\_\_

Have you ever had excessive bleeding from minor wounds or extractions? Yes \_\_\_\_\_, No \_\_\_\_\_, When? \_\_\_\_\_

**LIST ALL MEDICINES OR DRUGS YOU ARE NOW TAKING:** Including prescription or non prescription drugs, any over the counter medicines, or any recreational or illegal drugs and chemicals you have chosen to take:

NAME OF DRUG	HOW OFTEN EACH DAY	PURPOSE OF DRUG OR DISEASE BEING TREATED
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the practice named on the top of this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered by an insurance agreement and fees acquired in collecting these charges.

I agree to abide by guidelines set forth by this office as follows:

- Whenever possible allow 24-hours notice of canceled appointments.
- Pay for service at the time of the service.

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided here is complete and accurate.

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date