Dr. Greg A. Roberts
Oral and Maxillofacial Surgery

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So. Ogden, UT 84403

622 E. 4500 S. #202
Murray, UT 84107

Patient: (Mr., Mrs., Ms., Dr.) First Name_____M.I.____Last Name_____Date_____
Sex: Male □ Female □ Date of Birth_____Age_____Soc. Sec.#_____
Street_____City_____State_____Zipcode_____
Home Tel#:_____Work Tel#:_____Cell #_____Employer_____
Dentist:_____Medical Doctor:_____Referred By:_____
Driver's Lic.#:_____Nearest relative not living with you_____Tel.#_____
Have you ever been a patient of our practice? Yes □ No □ If so when? _____
Method of payment: Cash □ Check □ Credit Card □ CareCredit □ Other □ _____
Email_____

Who will be responsible for your account? Self □ Spouse □ Father □ Mother □ Other □ _____
Name_____Soc. Sec.#_____D.O.B._____Hm. Tel.# _____
Street_____City_____State_____Zipcode_____
Employer_____Work Tel.#_____Ext._____

Spouse or other guarantor information (if different from above)RELATION_____
Name_____ Soc.Sec.#_____D.O.B._____Hm. Tel#_____
Street_____City_____State_____Zipcode_____
Employer_____Work Tel.#_____Ext._____

INSURANCE INFORMATION HEALTH HISTORY

Patient: Student: Full Time □ Part Time □ Not □ School Name/Address_____
Marital Status: Married □ Leg.Seperated □ Widow □ Single □
Employment Status: Full Time □ Part Time □ Not □

PRIMARY ***DENTAL*** INSURANCE
Employer_____
Ins. Co. Name _____
Ins. Claims Address: _____
City _____State _____ Zip _____
Insurance Phone #: _____
ID #: _____**Group #:** ____
Subscriber: _____Relation_____
Sex: Female □ Male □ Date of Birth_____
Address_____
Soc.Sec.#: _____Tel.#_____

SECONDARY ***DENTAL*** INSURANCE
Employer _____
Ins. Co. Name _____
Ins. Claims Address: _____
City _____State _____Zip _____
Insurance Phone #: _____
ID #: _____**Group #:** _____
Subscriber: _____Relation _____
Sex: Female □ Male □ Date of Birth_____
Address_____
Soc.Sec.#: _____Tel.#_____

PRIMARY ***MEDICAL*** INSURANCE
Employer_____
Ins. Co. Name _____
Ins. Claims Address:_____
City _____State_____Zip _____
Insurance Phone #: _____
ID #: _____**Group #:** ____
Subscriber: _____ Relation _____
Sex: Female □ Male □ Date of Birth _____
Address_____
Soc.Sec.#: _____Tel.# _____

SECONDARY ***MEDICAL*** INSURANCE
Employer_____
Ins. Co. Name _____
Ins. Claims Address _____
City _____State _____Zip _____
Insurance Phone #: _____
ID #: _____**Group #:** ____
Subscriber: _____Relation _____
Sex: Female □ Male □ Date of Birth _____
Address _____
Soc.Sec.#: _____Tel.#_____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's visit: _____

	YES	NO
1. Are you in good health?	☐	☐
2. Have there been any changes in your general health in the past year?	☐	☐
3. Are you under the care of a physician? _____Date of last visit_____ if so, for what are you being treated? _____		
4. Have you had any illness, operation or been hospitalized in the past five years? if so, why?_____	☐	☐
5. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If so, describe where _____	☐	☐
6. Do you have a prosthetic joint/implant?_____If so, describe where_____		
7. Have you had a heart valve replacement or vascular graft?	☐	☐

	HAVE YOU HAD OR DO YOU CURRENTLY HAVE……	YES	NO		HAVE YOU HAD OR DO YOU CURRENTLY HAVE…….	YES	NO
8	Rheumatic fever?			34	Stroke?		
9	Damaged heart valves/mitral valve prolapse?			35	Thyroid trouble?		
10	Heart Murmur?			36	Diabetes?		
11	High Blood Pressure?			37	Low blood sugar?		
12	Low Blood Pressure?			38	Kidney trouble?		
13	Chest Pain, Angina?			39	Are you on dialysis?		
14	Heart Attack (s)?			40	Swollen ankles, arthritis or joint disease?		
15	Irregular Heart Beat?			41	Stomach ulcers?		
16	Cardiac Pacemaker?			42	Contagious diseases?		
17	Heart Surgery?			43	Sexually transmitted diseases?		
18	Bronchitis, Chronic Cough?			44	Problems with the immune system?		
19	Asthma?			45	Delay in healing?		
20	Hay Fever/ Sinus Problems?			46	A tumor or growth?		
21	Tuberculosis?			47	X-Ray treatment/chemotherapy?		
22	Emphysema?			48	Chronic fatigue/ night sweats?		
23	Difficulty breathing/ other lung trouble?			49	Are you on a diet?		
24	Do you smoke?			50	A history of drug abuse?		
25	Blood Transfusion?			51	A history of alcohol abuse?		
26	Blood Disorder such as anemia?			52	Contact lenses?		
27	Bruise Easily?			53	Eye disease/glaucoma?		
28	Bleeding Tendency (abnormal bleeding)?			54	Mental health problems?		
29	Jaundice, hepatitis or liver disease?			55	A removable dental appliance?		
30	Infectious Mononucleosis?			56	Pain & clicking of jaws when eating?		
31	Gallbladder Trouble?			57	Malignant hyperthermia?		
32	Fainting Spells?			58	**Anything to eat in the last 6 hours, or drink in the last 2 hours? (Only if you are having IV sedation today)**		
33	Convulsions, epilepsy?						

MEDICATIONS							
	ARE YOU NOW TAKING?……	YES	NO		ARE YOU NOW TAKING?……	YES	NO
59	Any kind of medication, drugs or pill?			62	Tranquilizers?		
60	Anticoagulants?			63	Cortisone?		
61	Diet Pills?			64	Other medications (please list below)		

LIST OF MEDICATIONS:

_____
_____
_____
_____

ALLERGIES							
	ARE YOU ALLERGIC TO OR HAD A REACTION TO……	YES	NO		ARE YOU ALLERGIC TO OR HAD A REACTION TO…….	YES	NO
65	Local anesthetics?			70	Codeine or other narcotics?		
66	Penicillin?			71	Other medications?		
67	Other antibiotics?			72	Allergies other than drug allergies? (please list)		
68	Sodium pentothal, valium, or other tranquilizers?						
69	Aspirin ?						
WOMEN							
73	Is there a possibility of pregnancy?			75	Are you nursing?		
74	Estimated delivery date__/__/__			76	Are you taking birth control pills?		

Women Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE MADE AWARE OF?

Yes □ No □ **If yes, please list:**_____

IS THERE A FAMILY HISTORY OF?: **Cancer** Yes □ No □ **Diabetes** Yes □ No □

Heart Disease Yes □ No □

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.

Signature of patient: _____ Date: _____
(parent or guardian if minor)

Signature of Physician: _____ Date:_____