

Associated Oral & Maxillofacial Surgeons of Peoria, Ltd.

Patient Information (Confidential)

A B C

Patient's Name _____ Male Female
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Birthdate _____ Age _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____ Full-time student? _____

Responsible Party Information (Confidential)

All Information is required before patient can be seen. Thank you.

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Birthdate _____ Age _____ Relationship to Patient _____ Social Security # _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name of Responsible Party _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Birthdate _____ Work Phone _____ Cell Phone _____ Social Security # _____

Dental / Medical Insurance Information

All information is required for us to submit your claim. Thank You.

Policy Holder's Name _____ D.O.B. _____ and Social Security # _____

DENTAL Insurance Company _____ Subscriber ID# _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

MEDICAL Insurance Company _____ Subscriber ID# _____ Group No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I authorize my insurance benefits be paid directly to Associated Oral & Maxillofacial Surgeons of Peoria. I authorize Associated Oral Surgeons to release pertinent medical/dental information to my insurance company when requested, or to facilitate payment of a claim. A credit bureau report may be obtained.

Signature of Patient (If under 18, signature of legal guardian): _____ Date: _____

Updates (date & initial) _____ Form No. AOS-005 (Rev. 10/06) *cmfi*

TURN FORM OVER AND COMPLETE OTHER SIDE →

MEDICAL HISTORY

CHECK ONE
Yes No

1. What is your reason for coming to our office? _____
 2. Are you now, or have you been, under the care of a physician during the past five years? _____
If yes, for what reason? _____
 3. Are you taking any medications or herbal remedies? _____
If yes, what? frequency? dose? _____
 4. Have you been given steroid (cortisone) therapy within the past year? _____
 5. Are you subject to (*Circle the problem you have*): Fainting, Dizziness, Nervous Disorders, Convulsions, Seizure Disorders? _____
 6. Do you have any artificial joints or bone plates? _____
If yes, where? _____
 7. Do you have pain, popping or clicking associated with your jaw joints? _____
 8. Have you ever had any breathing difficulty? _____
If yes, please check: No problems in past year Chronic Cough Pneumonia
 Hay Fever Bronchitis Tuberculosis
 Asthma Emphysema Any Lung Disorder
 9. Have you ever been treated for or diagnosed as having any of the following illnesses? _____
If yes, please check: Heart Trouble High Blood Pressure Anemia
 Heart Murmur Low Blood Pressure Glaucoma
 Stroke Hepatitis or Liver Trouble Diabetes: Controlled by Diet
 Rheumatic Fever Kidney Disease Controlled by Medication
 10. Do you have any tendency to prolonged bleeding? _____
If yes, how? _____
 11. Are you allergic or sensitive to any medications or latex? _____
If yes, what? _____
 12. Have you ever been sedated for a surgical or medical procedure? _____
If yes, for what? _____
 13. Have you ever had an unfavorable reaction to a local or general anesthetic? _____
If yes, what? _____
 14. Do you use (*Circle what you use*): tobacco, alcohol, or drugs? If yes, how much? _____
 15. Are you pregnant or nursing? _____
(If you are unsure, please check with your physician prior to any surgical procedure)
- Certain antibiotics prescribed in this office may interfere with the effectiveness of birth control pills.
It is recommended that you use an additional method of birth control during that cycle if antibiotics are prescribed.
However, continue the use of your birth control pills as prescribed.**
16. Do you have any diseases or medical problems not listed above? _____
If yes, what? _____

Height: _____ Weight: _____

Your Physician: _____ Last Seen (date): _____

Your General Dentist: _____ Last Seen (date): _____

Signature of Patient (If under 18, signature of legal guardian): _____

COMMENTS: _____

Updates (date & initial) _____