Legacy Surgery

Oral, Facial, & Dental Implant Specialists

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www.legacysurgery.com

Date:_____

Patient's Name: _____/_____/_____
(First) (Middle) (Last)

Mailing Address: _____

City/State/Zip: _____

Home Phone#: _____ Cell Phone#: _____

Date of Birth: _____ Age:_____ Sex: M__ F__ Height: _____ Weight:_____

Marital Status: _____ SSN:_____-_____-_____

Email Address: _____

Dentist:_____

Name of Person Referring You to Us: _____

How Did You Hear About Us? ___TV ___Radio ___Social Media ___Newspaper _____Other

Person to Notify in Case of Emergency: _____

Relationship: _____ Daytime Phone#:_____

Patient's Employer: _____ Phone#:_____

Spouse's Name**:** _____

Spouse's Employer: _____ Phone#:_____

Person Responsible for Bill: **(First/Middle/Last)** _____

Physical Address: _____

Marital Status: _____ Date of Birth: _____ SSN:_____-_____-_____

Spouse's Name & Date of Birth: _____

Relationship to Patient: _____

COMPLETE THE FOLLOWING IF PATIENT IS A MINOR

Father's Name:_____ Phone#:_____

Father's Employer: _____ Employer#:_____

Mother's Name: _____ Phone#:_____

Mother's Employer:_____ Employer#:_____

Health History Form

Patient's Name: _____ / _____ / _____
(FIRST/MIDDLE/LAST) DATE OF BIRTH TODAY'S DATE

	Yes	No
Are you currently under the care of a physician ……	☐	☐

Physician's Name _____

Practice Location _____

Date of Most Recent Physical Examination _____

Preferred Pharmacy for Prescriptions _____

Current Medications (prescribed, OTC, herbal):

_____

_____

_____

_____

Allergies: Are you allergic to or have you had a reaction to: (To all **yes** responses, specify type of reaction)	Yes	No
Local anesthetics _____	☐	☐
Aspirin _____	☐	☐
Penicillin or other antibiotics_____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Sulfa Drugs _____	☐	☐
Codeine or other narcotics _____	☐	☐
Latex (rubber) _____	☐	☐
Hay Fever / Seasonal _____	☐	☐
Animals / Food / Other _____	☐	☐

	Yes	No
Have you had unusual reactions or any problems associated with intravenous or general anesthesia?……..	☐	☐
Do you have a family history of problems associated with intravenous or general anesthesia?……	☐	☐
Do you wear contact lenses?…… …….……	☐	☐
Can you swallow pills?	☐	☐
Do you have a tongue piercing?	☐	☐
Have you ever had radiation to the head or neck?……..……..…….....	☐	☐

If yes, most recent treatment _____

Social History:	Yes	No
Do you use tobacco / nicotine products (smoking, snuff, chew, vape, etc.)? ..…….....	☐	☐
If yes, how often and what type _____		
Do you drink alcoholic beverages? …… …… ……..	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____		
If yes, how much do you typically drink in a week? _____		
Do you use recreational drugs?	☐	☐
If yes, how often do you use recreational drugs? _____		

PLEASE MARK (X) YOUR RESPONSE TO INDICATE IF YOU HAVE OR HAVE NOT HAD ANY OF THE FOLLOWING:

Cardiovascular System	**Yes**	**No**
Rheumatic / Congenital Heart Disease	☐	☐
Bacterial Endocarditis	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Pacemaker / Defibrillator	☐	☐
Chest Pain / Angina	☐	☐
Irregular Heart Rate	☐	☐
Coronary Artery Disease	☐	☐
Heart Surgery (Prosthetic Valve / Stent / Vascular Graft)	☐	☐
High Blood Pressure	☐	☐
Respiratory System	**Yes**	**No**
COPD	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Gastrointestinal System	**Yes**	**No**
Stomach Ulcers	☐	☐
Acid Reflux (GERD)	☐	☐
Genitourinary System	**Yes**	**No**
Dialysis	☐	☐
Endocrine System	**Yes**	**No**
Thyroid Disease	☐	☐
Diabetes (Type I / Type II)	☐	☐
Adrenal Tumor	☐	☐

Neurologic System	**Yes**	**No**
Fainting	☐	☐
Alzheimer's Disease	☐	☐
Dementia	☐	☐
Epilepsy	☐	☐
ADHD	☐	☐
Seizures	☐	☐
Depression / Anxiety	☐	☐
Psychiatric Disorders	☐	☐
Hepatic System	**Yes**	**No**
Cirrhosis of the Liver	☐	☐
Hepatitis	☐	☐
Hematologic / Immune System	**Yes**	**No**
Abnormal Bleeding (Aspirin, Coumadin, Plavix)	☐	☐
Blood Disorder (Leukemia, Anemia)	☐	☐
Lymphoma	☐	☐
Depression of Immune System	☐	☐
HIV / AIDS	☐	☐
Autoimmune Disease	☐	☐
Chemotherapy	☐	☐
FOR WOMEN ONLY:	**Yes**	**No**
Are you pregnant?	☐	☐
Are you taking birth control pills?	☐	☐
Are you nursing?	☐	☐
Is there any chance you might be pregnant?	☐	☐
****Antibiotics can impair the effectiveness of the pill****		

Any other conditions not listed above that the doctor should know about?

_____

_____

List Any Recent Operations, Hospitalizations, Organ Transplants and the Last Year:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Insurance Information

Patient's Name: _____ / _____ / _____
(FIRST/MIDDLE/LAST) DATE OF BIRTH TODAY'S DATE

MEDICAL INSURANCE

Primary Medical Insurance Company:_____

Employer's Name and Phone #:_____

Policyholders's Name: _____

Policyholder's Birthdate:_____ Policyholder's SSN: _____-_____-_____

ID #:_____ Group #:_____

Patient Relationship to Policy Holder:_____

Secondary Medical Insurance Company:_____

Employer's Name and Phone #:_____

Policyholders's Name: _____

Policyholder's Birthdate:_____ Policyholder's SSN: _____-_____-_____

ID #:_____ Group #:_____

Patient Relationship to Policy Holder:_____

DENTAL INSURANCE

Primary Dental Insurance Company:_____

Employer's Name and Phone #:_____

Policyholders's Name: _____

Policyholder's Birthdate:_____ Policyholder's SSN: _____-_____-_____

ID #:_____ Group #:_____

Patient Relationship to Policy Holder:_____

Secondary Dental Insurance Company:_____

Employer's Name and Phone #:_____

Policyholders's Name: _____

Policyholder's Birthdate:_____ Policyholder's SSN: _____-_____-_____

ID #:_____ Group #:_____

Patient Relationship to Policy Holder:_____