Oral and Maxillofacial Surgery

A Professional Corporation

DOUGLAS GALEN D.D.S.

Diplomate of the American Board of Oral and Maxillofacial Surgery

PLEASE PRINT. *This is important for our records and your health.*

PATIENT NAME _____
Last First Middle

HOME ADDRESS _____
Street

_____
City State Zip Code

HOME PHONE: _____ CELL PHONE: _____

EMAIL _____

MARK ONE: ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Child

MARK ONE: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

DATE OF BIRTH: _____ Age: _____ SOCIAL SECURITY NO.:_____

OCCUPATION: _____ EMPLOYER: _____

BUSINESS ADDRESS: _____ CITY: _____ TELEPHONE: _____

IF PATIENT IS MARRIED

NAME OF SPOUSE: _____ SOCIAL SECURITY NO.: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ TELEPHONE: _____

RESPONSIBLE PARTY (If patient is under 18 years of age, please provide parent/guardian's information)

NAME: _____ SOCIAL SECURITY NO.: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ TELEPHONE: _____

ALL PATIENTS

PRIMARY PHYSICIAN: _____ TELEPHONE: _____

DENTIST: _____ TELEPHONE: _____

INSURANCE

DO YOU HAVE DENTAL INSURANCE? ☐ Yes ☐ No _____
Company Name

DO YOU HAVE MEDICAL INSURANCE? ☐ Yes ☐ No _____
Company Name

NAME OF POLICY HOLDER: _____

SSN OR MEMBER ID : _____ MEMBER DATE OF BIRTH: _____/_____/_____

MEMBER ADDRESS: _____

We are not providers for any dental, medical or medicare insurance carriers. As a courtesy we will submit a claim to your insurance company (except medicare) and reimbursement will be directed to the insured.

Doctor or Person who referred you to our office:

Name / Names:_____

PLEASE COMPLETE THE MEDICAL HISTORY RECORD ON THE REVERSE SIDE

MEDICAL HISTORY

What is the reason for your visit today? _____

Please list any medications that you take regularly: _____

Have you received or currently taking bone enhancement medication? ☐Yes ☐No Describe: _____

Have you ever been hospitalized? ☐Yes ☐No Describe: _____

Have you ever had surgery? ☐Yes ☐No Describe: _____

Describe any illness for which you are being treated: _____

_____

Have you been treated by a physician or dentist in the last year? ☐Yes ☐No

For what? _____

Have you ever had an injury to your face or jaw? ☐Yes ☐No Describe: _____

Do you use tobacco? ☐None ☐Cigarettes ☐Cigar ☐Pipe ☐Chew / Snuff

Have you ever used tobacco? ☐No ☐Yes **If Yes:** Years of Use _____ Discontinued _____ Years ago

Alcohol consumption? ☐None ☐Light ☐Moderate ☐Heavy

Have you ever had any of the following?

Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Diabetes (Insulin or Non-Insulin dependent)
☐	☐	Hypertension	☐	☐	Glaucoma
☐	☐	Heart Attack	☐	☐	Cancer
☐	☐	Heart Murmur	☐	☐	Radiation Treatment
☐	☐	Rheumatic Fever	☐	☐	Chemotherapy
☐	☐	Heart Valve Replacement	☐	☐	Kidney Disease
☐	☐	Stroke	☐	☐	Liver Disease
☐	☐	Excessive Bleeding or Bruising	☐	☐	AIDS or HIV
☐	☐	Asthma	☐	☐	TMJ
☐	☐	Sinus Infection	☐	☐	Psychiatric Treatment
			Any Others?		_____

Yes	No	
☐	☐	Do you have chest pain upon exertion?
☐	☐	Are you ever short of breath on mild exertion? (i.e. climbing stairs)
☐	☐	Do you faint easily?
☐	☐	Does your jaw click or pop?
☐	☐	Do you have frequent headaches?
☐	☐	Is it difficult to open your mouth wide?
☐	☐	Are you dissatisfied with your smile, bite or facial profile?
☐	☐	Do you wear contact lenses?
☐	☐	Women: Are you pregnant? Do you think you might be pregnant?
☐	☐	Women: Do you take birth control pills?

Please indicate if you ever experienced an unusual or allergic reaction to any of these medications?

☐	Penicillin	☐	Valium Demerol Codeine	Describe the reaction: _____
☐	Erythromycin	☐	Percodan / Percocet Vicodin	Describe the reaction: _____
☐	Tetracycline	☐	Propofol	
☐	Keflex	☐	Local Anesthesia _____	Describe the reaction: _____
☐	Sulfa	☐	Epinephrine	Describe the reaction: _____
☐	Aspirin	☐	Others? _____	

I hereby certify that the above information is true and accurate and there have not been any omissions from my medical history. I consent to the taking of clinical photographs for the purpose of treatment and/or educational use. I authorize the release of any information to my insurance companies. I understand that Dr. Galen is not a provider for any medical or dental insurance plans and is not a Medicare provider. I understand that I will be financially responsible for all charges incurred and payment is due at the time that services are rendered. Should it be necessary to take any action against any of the parties to this agreement to enforce the provisions thereof or to take any action which is related to or arises out of this agreement, Douglas M. Galen, D.D.S. shall be entitled to all cost and expenses including but not limited to attorneys' fees, service charges and collection agencies fees incurred therein but not to exceed $5,000. Accounts extending over thirty days will be charged 0.833% interest per month.

Patient / Legal Guardian Signature _____ Date: _____