JON SHAFQAT, D.D.S

PATIENT INFORMATION & HEALTH HISTORY

PATIENT INFORMATION

Patient's Name _____
Last First Middle

Patient's Address _____
Street City State Zip

Home Phone _____ Age _____ Occupation _____

Cell Phone _____ Date of Birth _____ Social Security # _____

Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Spouse _____ Spouse's Phone _____

Nearest Relative (Not living with you) _____ Telephone _____

Referred by _____

Patient's Dentist _____ Patient's Physician _____

My chief complaint (why you have come to an oral surgeon): _____

Pharmacy Name _____ Street _____ City _____ Ph. No _____

CREDIT INFO

Person Responsible for Account _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Social Security # _____

DENTAL INSURANCE INFO

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Dental Insurance Name and _____

Address _____

ID# _____ Group # _____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Dental Insurance and _____

Address _____

ID# _____ Group # _____

MEDICAL INSURACE INFO

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Insured's Plan Name and _____

Address: _____

ID# _____ Group # _____

PLEASE COMPLETE OTHER SIDE

		Y	N
1.	Are you being treated for any condition by a Physician? Now ☐ or in the past year ☐	☐	☐
2.	Are you taking any medicines? Now ☐ or in the past year ☐	☐	☐
	Which ones? _____		
3.	Are you taking any natural product, herbal, supplement or tea, or other natural or homeopathic remedy?	☐	☐
	If yes, are you taking any prescription or non-prescription medications for the same purpose as the herbal remedy?	☐	☐
4.	Are you allergic to any drugs, medicines or latex products?	☐	☐
	Which ones? _____		
5.	Have you ever taken any prescription drug for osteoporosis?	☐	☐
6.	Have you ever taken any prescription diet medications such as Fen/Phen?	☐	☐
7.	Do you have a pacemaker?	☐	☐
8.	Have you ever had heart trouble?	☐	☐
9.	Have you ever been told by a physician that you have a heart murmur?	☐	☐
10.	Have you ever had rheumatic fever?	☐	☐
11.	Do you have high blood pressure?	☐	☐
12.	Have you ever had chest pain?	☐	☐
13.	Do you have shortness of breath?	☐	☐
14.	Do your ankles swell?	☐	☐
15.	Do you bleed excessively when cut?	☐	☐
16.	Do you have any blood disorder such as anemia?	☐	☐
17.	Have you ever had a stroke or any seizure disorders?	☐	☐
18.	Do you have asthma or any lung disease?	☐	☐
19.	Have you ever fainted?	☐	☐
20.	Do you smoke?	☐	☐
21.	Do you now have a cold or sore throat?	☐	☐
22.	Do you have diabetes?	☐	☐
23.	Have you ever had a thyroid condition?	☐	☐
24.	Have you ever had stomach ulcers?	☐	☐
25.	Have you ever had kidney problems?	☐	☐
26.	Have you ever had hepatitis or yellow jaundice?	☐	☐
27.	Have you ever tested positive for HIV?	☐	☐
28.	Have you ever had a history or glaucoma?	☐	☐
29.	Have you ever had radiation or cobalt treatments for cancer?	☐	☐
30.	Are you or could you possibly be pregnant?	☐	☐
31.	Have you had previous surgery of any kind?	☐	☐
	Type of surgery _____		
31.	Have you ever had reactions to local anesthetic (Novocaine) or a general anesthetic? (sodium pentothal)	☐	☐
32.	Do you have a history of sleep apnea or snoring?	☐	☐
33.	Do you have a hiatal hernia or gastric reflux?	☐	☐

Date _____ Signed _____

Patient, Parent or Guardian