HARTMAN
ORAL & MAXILLOFACIAL SURGERY

PATIENT INFORMATION

Name _____ Date _____
Last First M. Initial

Age _____ Sex _____ Date of Birth _____ Social Security No. _____

Address _____
Number Street Name

_____
City State Zip Code

Email Address _____

Home Phone _____ Primary ☐ Secondary ☐

Cell Phone _____ Primary ☐ Secondary ☐

Employer _____

Have you ever been a patient of this practice? NO YES
Has a family member ever been a patient of this practice? NO YES

Name of Dentist _____ Name of Orthodontist _____

Name of Physician _____ Referring Doctor _____

Spouse Information:
Name _____ Date of Birth _____
Social Security No _____ Employer _____
Telephone _____

PARENTAL INFORMATION (If Patient is a Minor or Student)

Father Name _____ Date of Birth _____
Social Security No _____ Employer _____
Telephone _____

Mother Name _____ Date of Birth _____
Social Security No _____ Employer _____
Telephone _____

EMERGENCY CONTACT

Name _____ Employer _____
Telephone (Cell)_____ Telephone (Alt.) _____

INSURANCE

Dental (Primary)

Insurance Company Name	Address	Telephone	Group Number
Identification Number	Name of Policy Holder	Relation to Policy Holder	

Medical (Primary)

Insurance Company Name	Address	Telephone	Group Number
Identification Number	Name of Policy Holder	Relation to Policy Holder	

Dental (Secondary)

Insurance Company Name	Address	Telephone	Group Number
Identification Number	Name of Policy Holder	Relation to Policy Holder	

Medical (Secondary)

Insurance Company Name	Address	Telephone	Group Number
Identification Number	Name of Policy Holder	Relation to Policy Holder	

(Please Initial Each Section)

_____I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and/or mobile phone concerning my appointment.

_____FEES & PAYMENTS We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit.An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

_____Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court costs.

_____ I hereby authorize video and/or photographic recording of any and all portions of my treatment performed by Dr. Michael Hartman. I understand this video may be used for non-profit purposes such as education, consultation, research and/or quality assurance. I understand that, while my identity will not be directly disclosed at any time in the records and all attempts will be made to conceal my identity it may be possible to identify me visually.

_____I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of Patient/Responsible Party Date

HARTMAN
ORAL & MAXILLOFACIAL SURGERY

HEALTH HISTORY

Name _____ Date of Birth _____

Height _____ Weight _____

	YES	NO
Are you in good health? ……..	☐	☐
Have there been any changes in your health in the past year? ……..…	☐	☐
Are you under the care of a physician? ……..….	☐	☐
Date of last visit _____		
For what are you being treated? _____		
Have you had any illness, operation, or hospitalization in the past five years? …..……...…	☐	☐
Please describe: _____		
Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in your mouth? ….	☐	☐
Please describe: _____		
Do you have a prosthetic joint/implant: ……....….	☐	☐
Please describe: _____		
Have you had a heart valve replacement or vascular graft?.....	☐	☐
Have you or a family member had any unusual or serious reactions to general anesthesia (Specify)?.....	☐	☐
Has a physician or dentist ever recommended that you take antibiotics prior to dental treatment? …….....	☐	☐
Do you take antibiotics regularly or prior to dentist visits? …….	☐	☐

Have you had, or do you have:	YES	NO
Rheumatic Fever		
Damaged heart valves/mitral valve prolapse		
Heart murmur		
High blood pressure		
Low blood pressure		
Chest pain/angina		
Heart attack(s)		
Irregular heart beat		
Cardiac pacemaker		
Heart surgery		
Pneumonia, bronchitis, chronic cough (Current)		
Asthma		
Hay fever/sinus problems		
Snoring/sleep apnea		
Difficult breathing/other lung trouble		
Tuberculosis		
Emphysema		
Do you smoke? # packs a day_____		
Do you use chewing tobacco		
Blood transfusion		
Blood disorder such as anemia		
Bruise easily		
Bleeding tendency/abnormal bleed		
Hepatitis, jaundice, or liver disease		
Gallbladder trouble		
Fainting spells		
Convulsions/epilepsy		

Have you had, or do you have:	YES	NO
Stroke		
Thyroid trouble		
Diabetes		
Low blood sugar		
Kidney trouble		
High cholesterol		
Are you on dialysis?		
Swollen ankles/arthritis/joint disease		
Osteoporosis/osteopenia		
Osteonecrosis		
Stomach ulcers/acid reflux		
Contagious diseases		
Sexually transmitted diseases		
Immune system problems (possibly from medication/surgery, etc)		
Delay in healing		
Tumor or growth		
Cancer/radiation therapy/chemotherapy		
Chronic fatigue/night sweats		
History of alcohol/drug abuse		
Contact lenses		
Eye disease/glaucoma		
Autism		
Mental health problems/anxiety/ depression		
Joint Replacement		
Removable dental appliance		
Pain or clicking of jaw		

Patient Name: _____

Is there a family history of:	Yes	No		Yes	No
Cancer …….....	☐	☐	Diabetes…….....	☐	☐
Heart Disease …….....	☐	☐	Anesthesia Problems…….....	☐	☐

Please list any surgeries you have had in the past:

Surgery:	Approximate Date:	Surgery:	Approximate Date:
_____		_____	
_____		_____	
_____		_____	

Are you now taking:	Yes	No
Blood thinners (Coumadin, Plavix, Aspirin, Pradaxa)	☐	☐
Are you taking, or have you taken, bone density meds (bisphosphonates) such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia? If so, when?	☐	☐

Please list any medications/supplements you are currently taking:

Medication:	Dosage:	Medication:	Dosage:
_____		_____	
_____		_____	
_____		_____	

Are you allergic to, or had a reaction to:	Yes	No		Yes	No
Local anesthetic (numbing agents).....	☐	☐	Codeine or other narcotics (Specify).....	☐	☐
Penicillin …….....	☐	☐	Other Medications …….....**.**	☐	☐
Other Antibiotics …….	☐	☐	Latex …….	☐	☐
Sulfa Drugs ……..	☐	☐	Soy ……	☐	☐
Sodium Pentothal/Valium/Tranquilizers	☐	☐	Eggs/Yolk …….....	☐	☐
Aspirin ……...	☐	☐	Sulfites ……..	☐	☐
Amoxicillin ……	☐	☐	Any known allergies? ……...	☐	☐

Please list any allergies other than drug allergies: _____

_____

	YES	NO
If you are having surgery today, have you had anything to eat or drink in the last 8 (eight) hours? ...….	☐	☐
Who is driving you home? _____ Phone: _____		
Is there any condition concerning your health that the doctor should be told about...……...…	☐	☐
If yes, please describe: _____		
Do you wish to speak with the doctor privately about anything? ……..….	☐	☐
Is this visit related to an accident? ……....….	☐	☐
Please describe: _____		

……..

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Reviewed by Doctor Date