GREENVILLE ORAL & MAXILLOFACIAL SURGEONS

Theodore G. Muchiteni, DMD * Richard A. Salzer, DMD**

2300 Hemby Lane

Greenville, NC 27834

Date: ____/___/____ **Patient Information** **Chart No.**:________

First Name	MI	Last Name	Sex: Male ☐ Female ☐
Date of Birth: _____/_____/______	Race:	Social Security Number: ______/_____/__________	
Single: ☐	Married: ☐	Separated: ☐	Divorced: ☐ Widow: ☐

Street/Temporary Address:	City:	State:	Zip:	Phone Number: ( )
Mailing Address:	City:	State:	Zip:	Cell or Alternate Number: ( )

In Case of Emergency: Contact: (not living with you)	Relation to You:	Phone Number: ( )

Occupation (Patient):	Employer (or School if Student):	
Employer's Address:		Business Phone Number: ( )
Name of Spouse: (or parent if under 16)	Social Security Number: ______/_____/_________	Employer:
Spouse's (or parent) Employer's Address:		Phone Number: ( )

Insurance Information

Insurance Company Name:____**Employer:**___________________________

Insured Person's Name:_________________________________**Birthdate:** _____/_____/_____**Relation to Patient:** ____________________

Address (if different from patient): ____

Phone Number:_(_______)______________**Insured's ID #**:___________________**Policy #**:________________**Group #**:_______________

Mail Claim to: ____

Referral Information

Name of Your Dentist:	Phone Number: ( )	Name of Your Physician:	Phone Number: ( )
Who referred you to us:			

Health History

Are you being treated for any of the following:	Yes	No	Do you have (or have had) any of the following:	Yes	No
1. Heart Disease?			1. Rheumatic heart disease or fever?		
2. Diabetes (sugar in blood)?			2. Heart Murmur?		
-Pills?			3. Implants placed anywhere in your body?		
-Insulin?			-Artificial heart valve?		
3. High Blood Pressure?			-Joint replacement?		
4. Anemia (low blood)?			-Shunts?		
5. Thyroid Gland disorder?			4. Hepatitis? A ☐ B ☐ C ☐		
6. Seizure Disorder (Epilepsy)?			5. Liver Disease (Jaundice)?		
7. Asthma?			6. Kidney Disease?		
8. Chronic Bronchitis or Emphysema?			-Dialysis?		
9. HIV/AIDS/ARC?			-Peritoneal?		
10. Osteoporosis?/Pagents?/Cancer?					

Are you allergic to or have you had an adverse reaction to:	Yes	No	Medications:	Yes	No
1. Local anesthesia (Novacaine, etc.)?			1. Are you taking blood thinners?		
2. Penicillin or other antibiotics?			-Coumadin?		
3. Codeine or other painkillers?			-Ticlid?		
4. Latex or rubber products?			-Aspirin?		
5. Sulfa Drugs?			-Lovenox?		
6. Other allergies or reactions? ____________________					

Other Pertinent Medical History: **Yes** **No**

1. Are you pregnant?........................ ___ ___
2. Do you smoke?............................ ___ ___
3. Do you use or have you ever used street drugs?................................ ___ ___
4. Have you been hospitalized recently? ___ ___

If yes, when ________________________________

What medications are you taking?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Do you have (or have had in the past) any other medical condition which was not indicated above? __________

If yes, ____

Comment: ____

____

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: ______________________ **Patient's Signature:** ______________________________