Oral & Facial Surgery of Delaware
OFSD
Rafetto & Campbell

# Personal and Health History Form

All information will be held in strict confidence

**Patient Information**

Patient's Name _____ Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip Code _____

Cell phone # _____ 2nd phone # _____ Email _____

Patient's Social Security No. _____ Employer _____

If Minor, Parent/Guardian's Name _____ Date of Birth _____

**Primary Dental Insurance Information**

Insurance Company _____ ID#/ Group# _____

Subscriber's Name _____ Relationship _____ Date of Birth _____

Address (if different from patient) _____

**Primary Medical Insurance Information**

Insurance Company _____ ID#/ Group# _____

Subscriber's Name _____ Relationship _____ Date of Birth _____

Address (if different from patient) _____

**Do you have secondary Medical Insurance? Company** _____

**If you have listed insurance coverage above, please sign the following statement, unless you wish to pay in full at the time of service, [I hereby authorize payment of benefits directly to Rafetto & Campbell, Oral and Facial Surgery for services performed.]**

Signature of insured _____

General Dentist _____ Who referred you to us? _____

What is your current dental problem? _____

What are your treatment goals? _____

**Acknowledgement of receipt of Notice of Privacy Practices**

I have viewed a copy of this office's Notice of Privacy Practices.

Signature of patient or guardian _____ Date _____

**PLEASE COMPLETE BACK OF FORM**

# MEDICAL - DENTAL HISTORY

(Circle one or complete the blanks)

Height Weight

Do you have any medical problems? YES NO

Have you ever been hospitalized? YES NO

If so, for what? _____

_____

Are you under the care of a physician? YES NO

If so for what? _____

Who is/are your Physician(s)? _____

_____

What operations have you had? _____

_____

Are you Pregnant or Nursing? YES NO

Do you have prosthetic heart valves? YES NO

Do you have any Prosthetic joints? YES NO

Do you take Blood thinners? YES NO

Do you take a bisphosphonate or injections for bone heatlh ? YES NO

Do you pre medicate for dental procedures? YES NO

Do you smoke? YES NO

If yes, how much?

Do you drink alcohol YES NO

If yes, how much?

Do you use marijuana or other illicit drugs? YES NO

**What medications and supplements are you taking?**

_____

_____

**What medications or other things are you allergic to?**

_____

**Do you have any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| Heart Disease | YES | NO | Diabetes | YES | NO |
| Heart Murmur | YES | NO | Blood Disorder | YES | NO |
| Pace Maker | YES | NO | Clotting Disorder | YES | NO |
| Blood Pressure | YES | NO | Recent Weight Change | YES | NO |
| Chest Pain | YES | NO | Sleep Apnea | YES | NO |
| Asthma | YES | NO | Contact Lenses | YES | NO |
| Lung Disease | YES | NO | Fainting or Dizziness | YES | NO |
| Tuberculosis | YES | NO | Sinus or Nasal Problems | YES | NO |
| Frequent Cough | YES | NO | Jaw Joint Problems | YES | NO |
| Shortness of Breath | YES | NO | Mental/Emotional Disorder | YES | NO |
| Liver Disease | YES | NO | History of Cancer, Chemo, or Radiation | YES | NO |
| Hepatitis | YES | NO | Sexually Transmitted Disease | YES | NO |
| Kidney Disease | YES | NO | Osteoporosis or Osteopenia | YES | NO |
| Neurological Disorder | YES | NO | Immune Deficiency (Lupus, RA etc.) | YES | NO |
| Cognitive Disorder | YES | NO | Have you had any problems with: | | |
| Epilepsy or Seizure Disorder | YES | NO | • Local Anesthesia | YES | NO |
| | | | • General Anesthesia or Sedation | YES | NO |

Do you have any other diseases, conditions or problems not listed above that you think the doctor should know about? YES NO

Do you wish to talk to a doctor privately about anything? YES NO

I certify that all information on this history form is true and correct.

**Signature of patient** (guardian, if the patient is a minor) _____