

# ORAL SURGERY/IMPLANT CONSULTATION

Form 401C

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

## PATIENT INFORMATION

TODAY'S DATE: \_\_\_\_\_

MR.  MS  MISS  MRS.  DR. NAME: \_\_\_\_\_  
FIRST MIDDLE INITIAL LAST

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_  MALE  FEMALE

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

HOW LONG AT CURRENT ADDRESS? \_\_\_\_\_ (IF LESS THAN 3-YEARS PLEASE GIVE PREVIOUS ADDRESS)

PREVIOUS ADDRESS \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

ADDRESS: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

SS#: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_

ADDRESS IF DIFFERENT FROM PATIENT \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

FAMILY DENTIST \_\_\_\_\_

ADDRESS \_\_\_\_\_

## DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

Yes  No  Diet limited to semisolid food or soft foods

Yes  No  Diet limited to liquid foods

Yes  No  Difficulty chewing

Yes  No  Difficulty speaking

Yes  No  Difficulty swallowing

Yes  No  Digestive problems

Yes  No  Facial pain

Yes  No  Gagging easily

Yes  No  Head pain

Yes  No  Jaw clicks

Yes  No  Jaw locks

Yes  No  Limited opening of jaw

Yes  No  Loss of teeth

Yes  No  Are you currently in pain? \_\_\_\_\_

Yes  No  Do you feel your oral condition is affecting your general health in any way? \_\_\_\_\_

Yes  No  Mouth sores

Yes  No  Numbness in lower lip

Yes  No  Numbness in jawbone

Yes  No  Tingling in jawbone

Yes  No  Nutritional disorders

Yes  No  Pain in jaw bone

Yes  No  Pain in jaw joint

Yes  No  Pain when swallowing

Yes  No  Pain when chewing

Yes  No  Poorly fitting dental appliance

upper  lower

Yes  No  Teeth do not meet properly

Yes  No  Other

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:**

- |   |  |
|---|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics       | Y <input type="checkbox"/> N <input type="checkbox"/> Metals         |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin           | Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin     |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates      | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic        |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine           | Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives      |
| Y <input type="checkbox"/> N <input type="checkbox"/> Iodine            | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Latex             | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics |  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other _____       |  |

**LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:**

- |  |  |
|--|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics      | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin          |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants   | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates     | Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills      |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners   | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine          | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone        | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs      |
| Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills       | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication |  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other _____      |  |

**PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:**

Practitioner	Specialty	Treatment & Approximate date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MEDICAL HISTORY (Please indicate dates on questions checked YES)**

- |   |   |   |
|---|---|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Abnormal bleeding after surgery or injury                                 | Y <input type="checkbox"/> N <input type="checkbox"/> Excessive thirst              | Y <input type="checkbox"/> N <input type="checkbox"/> Injury to<br><input type="checkbox"/> Face <input type="checkbox"/> Mouth<br><input type="checkbox"/> Neck <input type="checkbox"/> Teeth |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anemia  | Y <input type="checkbox"/> N <input type="checkbox"/> Fainting spells               |   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Arteriosclerosis  | Y <input type="checkbox"/> N <input type="checkbox"/> Fluid retention               | Y <input type="checkbox"/> N <input type="checkbox"/> Insomnia  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Asthma  | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent cough                | Y <input type="checkbox"/> N <input type="checkbox"/> Intestinal disorders  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Autoimmune disorders  | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent illnesses            | Y <input type="checkbox"/> N <input type="checkbox"/> Jaw joint surgery   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bleeding easily   | Y <input type="checkbox"/> N <input type="checkbox"/> Frequent stressful situations | Y <input type="checkbox"/> N <input type="checkbox"/> Kidney problems   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bloating  | Y <input type="checkbox"/> N <input type="checkbox"/> General anesthesia            | Y <input type="checkbox"/> N <input type="checkbox"/> Liver disease   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | Y <input type="checkbox"/> N <input type="checkbox"/> Glaucoma                      | Y <input type="checkbox"/> N <input type="checkbox"/> Meniere's disease   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Bruising easily   | Y <input type="checkbox"/> N <input type="checkbox"/> Gout                          | Y <input type="checkbox"/> N <input type="checkbox"/> Menstrual cramps  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cancer  | Y <input type="checkbox"/> N <input type="checkbox"/> Hay fever                     | Y <input type="checkbox"/> N <input type="checkbox"/> Multiple sclerosis  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chemotherapy  | Y <input type="checkbox"/> N <input type="checkbox"/> Headaches                     | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle aches  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic Bronchitis  | Y <input type="checkbox"/> N <input type="checkbox"/> Hearing impairment            | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle shaking (tremors)  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic fatigue   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart murmur                  | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle spasms or cramps   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Chronic mouth dryness   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart disorder                | Y <input type="checkbox"/> N <input type="checkbox"/> Muscular dystrophy  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Cold hands & feet   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart pacemaker               | Y <input type="checkbox"/> N <input type="checkbox"/> Needing extra pillows to help breathing at night  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Colitis   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart palpitations            | Y <input type="checkbox"/> N <input type="checkbox"/> Nervous system irritability   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Current pregnancy   | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve replacement       | Y <input type="checkbox"/> N <input type="checkbox"/> Nervousness   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Depression  | Y <input type="checkbox"/> N <input type="checkbox"/> Heart valve damaged           | Y <input type="checkbox"/> N <input type="checkbox"/> Neuralgia   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes  | Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia                    | Y <input type="checkbox"/> N <input type="checkbox"/> Osteoarthritis  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Dizziness   | Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis                     | Y <input type="checkbox"/> N <input type="checkbox"/> Osteoporosis  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Emphysema   | Y <input type="checkbox"/> N <input type="checkbox"/> Hypoglycemia                  | Y <input type="checkbox"/> N <input type="checkbox"/> Ovarian cysts   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy  | Y <input type="checkbox"/> N <input type="checkbox"/> Immune system disorder        | Y <input type="checkbox"/> N <input type="checkbox"/> Parkinson's disease   |

Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL HISTORY Continued**

- Y  N  Poor circulation
- Y  N  Prior orthodontic treatment
- Y  N  Psychiatric care
- Y  N  Radiation treatment
- Y  N  Rheumatic fever
- Y  N  Rheumatoid arthritis
- Y  N  Scarlet fever

- Y  N  Seizures
- Y  N  Shortness of breath
- Y  N  Sickle Cell Anemia
- Y  N  Sinus problems
- Y  N  Skin disorder
- Y  N  Slow healing sores
- Y  N  Speech difficulties
- Y  N  Stomach ulcers
- Y  N  Stroke

- Y  N  Swelling of ankles
- Y  N  Swollen, stiff or painful joints
- Y  N  Tendency for:
  - Y  N  Frequent Colds
  - Y  N  Ear Infections
  - Y  N  Sore Throats
- Y  N  Tired muscles
- Y  N  Tuberculosis
- Y  N  Tumors
- Y  N  Urinary disorders

Y  N  Other Medical/Dental History \_\_\_\_\_

Do you take aspirin regularly  Yes  No

Smoke tobacco  Yes  No

Has any close relative had a serious illness or condition  Yes \_\_\_\_\_  No

Emotional or nervous disturbances?  Yes  No

If yes, please explain \_\_\_\_\_

**COMPLETE THIS SECTION IF YOU WERE INVOLVED IN AN ACCIDENT OR A TRAUMATIC INCIDENT RELATED TO THIS VISIT THE PATIENT BELIEVES THE CAUSE OF THE PAIN OR CONDITION TO BE:**

- A motor vehicle accident
- A motorcycle accident
- A work related incident
- A playground incident
- An athletic endeavor
- A fight
- A fall
- An accident
- Unknown
- Other \_\_\_\_\_

DATE OF ACCIDENT OR INCIDENT: \_\_\_\_\_

**HISTORY OF ACCIDENT**

WERE YOU ?

- A passenger in a vehicle
- The driver of a vehicle
- A pedestrian
- At work

- Did you fall?
- Were you hit by an object?
- Did you hit an object?
- Other \_\_\_\_\_

IF IN A VEHICLE WHERE WAS THE VEHICLE HIT?

- At front end
- At rear end
- At front right area
- At front left area
- At rear right area
- At rear left area

- Head on
- On driver's side
- On passenger's side
- Other \_\_\_\_\_

INDICATE IF THERE WAS ANY DIRECT TRAUMA:

DID YOUR

- Forehead
- Face
- Chin
- Side of head
- Back of head
- Top of head
- Teeth
- Jaw
- Other \_\_\_\_\_

FORCIBLY STRIKE

- Steering wheel
- Windshield
- Passenger's side window
- Driver's side window
- Passenger's side door
- Driver's side door
- Headrest
- Seat
- Roof
- Interior of car
- Other \_\_\_\_\_

TEETH WERE

- Sore
- Missing
- Loose
- Broken
- Other \_\_\_\_\_

AFTER THE ACCIDENT

BRIEFLY DESCRIBE THE HISTORY OF SYMPTOMS, ACCIDENT OR INCIDENT: \_\_\_\_\_

**FOR OFFICE USE**

Extent of medical history obtained on \_\_\_\_\_ consisted of: \_\_\_\_\_ (date)

- Chief Complaint(s)
- Review of systems related to problem
- Complete past history
- Extended history of present illness
- Review of all additional body systems
- Complete family history
- Complete social history

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**FAMILY HISTORY**

Have any members of your family (blood kin) had: Y  N  Headaches Y  N  High blood pressure  
 Y  N  Heart disease Y  N  Diabetes

**SOCIAL HISTORY**

Occupation \_\_\_\_\_

Do you have children? Y  N  If yes, how many children? \_\_\_\_\_ What are their ages? \_\_\_\_\_

Y  N  Are you currently under unusual stress?

Y  N  Do you chew tobacco?

Y  N  Recent change in lifestyle?

Number of caffeine drinks per day \_\_\_\_\_

Y  N  Do you exercise regularly?

Y  N  Do you smoke?

\_\_\_\_\_ Number of  Packs  Cigarettes per  Day  Week

*Alcohol consumption*

\_\_\_\_\_ Number of drinks per  Day  Week  Month

**INSURANCE INFORMATION**

**INSURANCE #1 (MEDICAL/DENTAL/AUTO/OTHER)**

Insured's Name \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_  
 Relationship \_\_\_\_\_ Insured's Birth date. \_\_\_\_\_  
 Insured's Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Insurance Billing Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_

**MEDICAL INSURANCE #2 (MEDICAL/DENTAL/AUTO/OTHER)**

Insured's Name \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_  
 Relationship \_\_\_\_\_ Insured's Birth date. \_\_\_\_\_  
 Insured's Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_  
 Insurance Billing Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_ I.D. No. \_\_\_\_\_

I authorize the release of a full report of examination findings, diagnosis, treatment program, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**FOR OFFICE USE ONLY**

Insurance Company \_\_\_\_\_  
 Group Health     Auto     Government     Self Insured     Dental  
 Contact Person \_\_\_\_\_ Phone No. \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Effective date of this policy \_\_\_\_\_ Policy exclusions \_\_\_\_\_  
 Amount of deductible? \_\_\_\_\_ Has it been satisfied? \_\_\_\_\_  
 At what percentage are benefits paid? \_\_\_\_\_  
 Policy maximum? \_\_\_\_\_  
 Is precertification required     Yes     No    Can benefits be assigned to doctor?     Yes     No  
 What information is needed to process this claim? \_\_\_\_\_  
 For No Fault: Amount of benefits \_\_\_\_\_ Adjuster \_\_\_\_\_  
 Other \_\_\_\_\_

