ARBOR VIEW
ORAL & FACIAL SURGERY

PATIENT INFORMATION FORM

Please complete this form to the best of your ability. Questions? Just ask!

TELL US A BIT ABOUT YOU

Patient's full name _____ Preferred name _____

Gender: ☐ Male ☐ Female ☐ _____ Family status: ☐ Single ☐ Married ☐ _____

Birth date _____ Social security number _____

HOW DO WE CONTACT YOU

Home address _____ City _____ State _____ ZIP _____

Home phone _____ Work phone _____ Mobile phone _____

Email _____ Best way to reach you: ☐ Home phone ☐ Mobile phone ☐ Work phone ☐ Email

LET'S TALK ABOUT TODAY'S VISIT

Reason for visit _____

How did you hear about us: ☐ Referred by: _____ ☐ _____

Emergency contact _____ Relationship _____ Phone _____

DENTAL HISTORY

Your general dentist name _____ Dentist phone _____

Other dental specialist _____ Specialist phone _____

Date of your last dental exam _____

Are you prone to canker or cold sores? (mouth or lip sores) ☐ Yes ☐ No

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FINANCIAL RESPONSIBILITY (SKIP IF PATIENT IS SOLELY RESPONSIBLE)

Name of responsible financial party | Relationship

Address (if different)

Home phone | Work phone | Mobile phone

Birth date | Social security number

DENTAL INSURANCE

Name of insured | Relationship | Insured birth date

Insurance plan name | Insurance company phone

Member/subscriber ID # | Plan/group #

Claims address

Subscriber's ☐ Employer ☐ School | Address | City | State | ZIP

MEDICAL INSURANCE (SKIP IF YOU'RE PROVIDING AN INSURANCE CARD)

Name of insured | Relationship | Insured birth date

Insurance plan name | Insurance company phone

Member/subscriber ID # | Plan/group #

Claims address

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MEDICAL HISTORY

Your primary care physician's name _____ Office phone _____ Date of last exam _____

☐ Check if you've ever been hospitalized. Please explain: _____

☐ Check if you've taken medications for osteoporosis or bone cancer. Please explain: _____

☐ Check if you've had chemotherapy or radiation therapy. Please explain: _____

☐ Check if you're pregnant / trying to get pregnant / breast feeding. Please explain: _____

CHECK IF YOU HAVE OR HAVE BEEN TREATED FOR THE FOLLOWING CONDITIONS:

☐ Asthma	☐ Kidney disease	☐ Arthritis
☐ Bronchitis/cough	☐ Liver disease/jaundice	☐ Artificial joints
☐ Chronic Sinus conditions	☐ Cancer	☐ Birth defects
☐ Shortness of breath	☐ Chemotherapy	☐ Mobility limitations
☐ Tuberculosis	☐ Thyroid conditions	☐ Hives/rashes/skin conditions
☐ Lung conditions	☐ Diabetes	☐ Blood disorder
☐ Sleep apnea/CPAP use	☐ Immunodeficiency	☐ Hepatitis type _____
☐ Pacemaker	☐ Epilepsy/seizures	☐ Eating disorder
☐ Heart attack	☐ Fainting/syncope	☐ Alcohol dependency
☐ Heart conditions	☐ Mental health/psychiatric conditions	☐ Drug dependency
☐ Anemia	☐ Eye conditions	☐ Tobacco use
☐ Heart murmur	☐ Stroke	☐ Chronic infections
☐ Chest pains/angina	☐ Memory/brain conditions	☐ Self-care limitations
☐ High blood pressure	☐ Concussion	☐ HIV/AIDS
☐ _____	☐ _____	☐ _____

_____
List your medications and prescriptions

_____
List your allergies

Are you a user of ☐ Cigarettes/Tobacco ☐ Vape ☐ Alcohol ☐ Drugs and substances

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PHARMACY & CORRESPONDING PROVIDERS

Pharmacy name | Phone

Location

Coordinating doctors or providers (if any) | Phone

ALMOST DONE!

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Patient name (please print)

Patient or legal guardian signature | Date

Witness signature | Date