Gainesville
Oral and Maxillofacial Surgery

Fred H. Simonton III, DMD

First name _____ M.I. _____ Last name _____ Nickname _____

Address _____City _____ State _____ Zip _____

Home phone (_____)_____ Work phone (_____)_____ Email _____

Employer _____ Occupation _____ Marital Status _____

Date of birth _____ Sex: Male Female Age _____ S.S. # _____

Person responsible for bill _____ Relationship to patient _____

Address if different from patient _____

Home phone (_____)_____ Work phone (_____)_____ DOB _____

Employer _____ S.S. # _____

Reason for visit _____ Please Circle

Do you now or have you ever had pain, swelling, pressure, infection or bleeding YES NO Upper left Upper right

from wisdom teeth? Lower left Lower right

Dentist _____ Physician _____ Referred by: _____

Person to contact in case of an emergency _____ Phone (_____)_____

HEALTH HISTORY *Please complete every line*

List **all** medications you are currently taking _____

_____

List **all** previous surgeries and give dates _____

_____

Are you allergic or have you reacted adversely to any of the following medications? Please circle all that apply

Penicillin	Demerol	Tetracycline	Darvon	Eggs	Erythromycin	Local
Aspirin	Latex	Other antibiotics	Percodan	Codeine	Valium	anesthetic

Allergy to any other medication or substance? Yes No If yes, please list: _____

Patient's weight _____ Patient's height _____

HEART DISEASE

YES NO Congestive heart failure
YES NO Heart attack
YES NO Chest pain
YES NO High blood pressure
YES NO Murmur/valve disorder
YES NO Rheumatic fever
YES NO Mitral valve prolapse
YES NO Pacemaker
YES NO Heart Surgery
YES NO Irregular heartbeat

LUNG DISEASE

YES NO Asthma
Date of last attack:_____
YES NO Emphysema
YES NO Smoke tobacco
# of yrs _____ Packs/day_____
YES NO Sleep apnea
YES NO Chronic cough

ENDOCRINE DISEASE

YES NO Diabetes
YES NO Thyroid

INFECTIOUS DISEASE

YES NO HIV/AIDS
YES NO Hepatitis A/B/C
YES NO Tuberculosis
YES NO Venereal
YES NO Other

MUSCULOSKELETAL DISEASE

YES NO Fibromyalgia
YES NO Arthritis
YES NO Connective tissue disease
YES NO Lupus
YES NO Artificial joint
YES NO Osteporosis
YES NO Jaw joint pain/dysfunction

NEUROLOGIC DISEASE

YES NO Neuromuscular
YES NO Stroke
YES NO Seizures,epilepsy
YES NO Migraine headaches

FEMALE ONLY

YES NO Birth control
YES NO Pregnant
(Antibiotics may interfere with the effectiveness of oral contraceptives. Consult your physician for advice regarding other methods of birth control)

BLOOD/CLOTTING DISORDER

YES NO Prolonged bleeding
YES NO Anemia
YES NO Hemophilia
YES NO Platelet disorder
YES NO Bruising
YES NO Aspirin usage

ANESTHESIA HISTORY

YES NO General anesthesia
YES NO Complications
YES NO Post-op nausea
YES NO High fever
YES NO Prolonged recovery

OTHER

YES NO Liver disease
YES NO Kidney disease
YES NO Cancer treatment
YES NO Chewing tobacco
YES NO Taking diet pills
YES NO Psychiatric care
YES NO Ulcers
YES NO Drug addiction
YES NO Alcohol use
YES NO High cholesterol
YES NO Osteoporosis meds

Is there any health condition not listed above? Yes No If YES, please list: _____

_____

I have read, understand, and answered the questions above. I will not hold my surgeon, or any other member of his staff responsible for any errors or omissions that I have made in completion of this form. I hereby assign all benefits to which I am entitled to Dr. Simonton. I authorize the release of all information my insurance company requests.

Signature of Patient/Guardian _____ Date _____