Maxillofacial Surgery Center
Patrick A. Abbey, D.M.D., P.A
Diplomate of the American Board of Oral & Maxillofacial Surgery

Patient Information

Name of Patient: _____
Age: _____ Weight: _____ Sex: _____ D.O.B.: _____
Referred by: _____
Name of Family Physician: _____
Are you presently or within the past year under the care of a physician? ☐ Yes ☐ No
Why? _____

Are you now or in the past been treated for any of the following conditions? Please check the appropriate column.

	YES	NO		YES	NO
Heart Conditions			Allergy to Food or Drugs?		
Heart Murmur (Rheumatic Fever)			If so What?		
Stroke			Epilepsy (Seizures)		
Diabetes			Excessive Bleeding		
Hepatitis			Are you Pregnant?		
Kidney (disease)			Arthritis		
Asthma			Pneumonia		
Thyroid Conditions			TB		
High Blood Pressure			Emphysema		
Anemia			Angina (Chest Pain)		
HIV			Glaucoma		

Other medical conditions? _____

Have you had general anesthesia in the past, either in the hospital or in office? _____

Do you now or have in the past, taken any of the following drugs?

	YES	NO
Heart Medicine		
Steroids (Cortisone)		
High Blood Pressure Pills		
Sedatives (Valium)		
Diuretic (Water Pills)		
Kidney (disease)		
Thyroid		
Drug Addiction		
Alcoholism		
Medication for Osteoporosis		
Other:		

Are you currently taken any medications?

	YES	NO
Blood Thinner (Coumadin, Dicoumarol)		
Insulin		
Dilantin		
Tranquillizers		
Penicillin		
****List of Current Medications:**		

In your own words, describe what brought you to our office: _____

I certify that I have read and understand the Medical Questionnaire and that the answers given by me are true to the best of my knowledge. I hereby authorize the doctor in charge of the treatment or administer any necessary anesthetic and perform such operation as may be deemed necessary or advisable in the diagnosis or treatment of this patient. I understand that I am responsible for all charges, whether paid by my insurance. I hereby authorize Dr. Abbey to release all information necessary to secure reimbursements from any insurance company to which I have subscribed. [have read and understand the above and agree to comply. Must be signed by a responsible adult.

Signed: _____ Date: _____

Reviewed by: _____ Date: _____

24-HOUR NOTICE EXPECTED IN EVENT OF CANCELLATION OF APPOINTMENTS

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