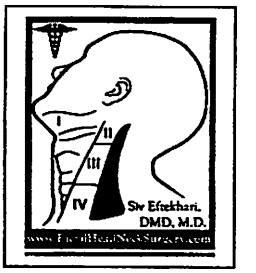


NextGen Oral MaxilloFacial & Reconstructive Surgery Center

History and Physical Intake Form

Siavash Siv Eftekhari, DMD, M.D.

Patient Full Name: _____ **Current Address:** _____
Patient DOB: _____ _____
Best contact phone #: _____ **Emergency contact name and phone:** _____

Patient's Primary Care Physician: _____ **Phone #** _____
If no primary care physician is known please place N/A in the following blanks

What is your current *Height*_____ *Weight*____ **Food/ Drug Allergies if** *NONE or*: _____

Past Medical History; Circle any area that applies to you:

Allergy Prone
Hay fever
Latex
Sinusitis
Seasonal

Bone or Joint
Arthritis, Rheumatism
Artificial Joint/ when _____
Back Problems
Surgical Implant

Cancer
Where_____
Chemotherapy
Radiation Therapy

Past/Present Alcohol use: Yes No
How often per week: _____

Past/Present Drug use: Yes No
When: _____How often per week:_____

Circulation
AIDS/HIV
Anemia
Bleeding Problems
Blood Disease
Blood Transfusion
Feet/Ankle Swelling
Hemophilia
High Blood Pressure
Emphysema

Cortisone Treatment
Diabetes
Glaucoma
Heart
Angina (chest pain)
Heart Disease or Failure
Heart Attack
Heart Murmur
Heart Surgery (Bypass)
Pacemaker
Rheumatic Fever
Stroke
Swollen Ankles

Kidney Disease/Transplant
Liver Disease
Hepatitis- Type: A B C
Notes:_____

Lung Disease
Asthma
Bronchitis
Pneumonia
Shortness of Breath
TB

Nervous Problems
Epilepsy
Seizures
Psychiatric care

Skin Problems
Skin Cancer
Herpes
Cold Sores

Sleep Disorder
Snoring
Sleep Apnea/CPAP machine

Thyroid Disease
Tobacco
Smoke (pack per day ____)
Dip
# of Years____

Tonsillitis
Mouth Ulcers

**** List other past/current Medical conditions:***
_____
_____
_____
_____

**** List past surgeries (even childhood) with dates:***
_____
_____
_____
_____
_____

If have High Blood Pressure or history of Heart disease:

Any recent chest pain: YES NO **Any Shortness of Breath:** YES NO **Able to go up 3 flights of stairs/ 2 city blocks:** YES NO

If Diabetic: **Recent Hemoglobin A1C**_____**Recent Blood Sugar**_____ **Any Diabetic Emergencies Ever:** YES NO

If Asthmatic: **Any ER visits, Hospitalizations:** YES NO When _____

Are you taking any natural product, herbal supplement or tea, or other natural or homeopathic remedy? YES NO

Drug or Alcohol abuse:
Do you have history of social drug use currently or in the past? .....**YES NO**
Recreational drug use, overdose with medication, or excessive alcohol consumption can adversely affect the liver function which is critical for producing blood clotting factors. Disclosure will allow your surgeon to safely treat you and prevent excessive post-surgical bleeding and can be life threatening.

Current recreational drug use: interaction with local anesthesia and IV sedation agents can be life threatening. Full disclosure is critical for safe management. information is strictly confidential.

Women:

Is there any reason to suspect you may be pregnant? ..... **YES NO**

Pregnancy : I understand that if there is a possibility of current pregnancy, surgery will be postponed (only IV Sedation/General Anesthesia) until I complete either a home or blood pregnancy test prior to scheduling IV sedation /general anesthetic procedure and report results to my treating surgeon. Medication used during the surgery and post-operative period can adversely affect the developing baby.

Are you on birth control medication?.. ... **YES NO**

Are you breast feeding? ..... **YES NO** if YES, please talk to you PCP prior to sedation

Birth Control Pills: Antibiotics are commonly prescribed during your surgical management. Antibiotics can decrease the efficacy of the birth control pill leading to pregnancy. It is recommended that a second alternative form of birth control be used for the full cycle (month) if pregnancy is not desired.

Medical Alert (All Patients):

Are you now or have you even been treated with oral or intravenous bisphosphonates (bone strengthening medication) for **Osteoporosis / Osteopenia/ Arthritis / Cancer / Bone Metastases?** Failure of disclosure can lead to complications in bone healing (Osteonecrosis of the jaw bone) which are very difficult to treat and is a serious side effect of these medications.

Are you using or have you ever used any of the oral or IV bisphosphonate medications?..... **YES NO**

Examples of Oral Forms: Fosamax, Actonel, Skelid, Didronel, Boniva

Examples of Intravenous Forms : Zometa, Aredia

If yes, please circle medication and reason for taking medication and for how many years _____

Any history of Patient/family issues with ANESTHESIA (difficulty getting numb, waking up in the middle of surgery, fevers during anesthesia, nausea/vomiting or slow to wake up) or BLEEDING: **YES NO; if yes please explain:** .....

Any fevers, coughs, sore throats, runny noses, active infection in the last week: **YES NO; if yes please explain:**.....

Any history of recent hospitalization: **Yes No;** if yes please explain: .....

Review of My Symptoms

Yes	No	Symptoms	Yes	No	Symptoms
		Snoring			Swelling
		Pain with chewing			Limited mouth opening
		Recent dental work			Pus (infection in your mouth, face, or neck)
		Sinus pain			Difficulty swallowing
		Bad breath			Pain on swallowing
		Difficulty breathing, shortness of breath			Numbness or tingling on face or neck
		TMJ pain			Fevers or chills
		Dry mouth			Facial or Oral/Jaw pain
		Nose bleeding			Nausea/Vomiting
		Neck Pain			Voice change

Current Home Medications:

(Please list ALL medications that you are currently taking at this time or have within the last year)

Provide us with a current list of medications if you have one

_____ _____

_____ _____

_____ _____

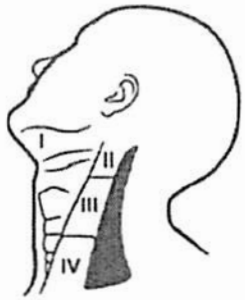
Authorization: The responses to this questionnaire are accurate to the best of my knowledge. If there is any change in my medical status I will inform the doctor. I authorize my insurance company to pay the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or for my dependents. I understand and authorize all dishonored check, plus processing fee with applicable taxes to be electronically debited from my account.

Signature: **Date:**

Care Taker/Legal Guardian: **Date:**

NextGen Oral MaxilloFacial & Reconstructive Surgery Center

Demographics **Dr. Siavash Eftekhari MD,DMD**



Patient Name: _____

Date Of Birth: _____

Age: _____

SSN: _____

Medical Conditions: _____

_____

_____

Allergies: _____

_____

_____

Latex Allergy?: Yes or No

Current Medications: _____

_____

_____

Primary Care Physcian: _____

_____

Primary Care Physicains #: _____

Referral From? Doctor Insurance Hospital

Please Specify: _____

_____

Home Address: _____

_____

Email Address: _____

Cell Phone #: _____ **Text OK?:** Yes or No

Medical & Dental Insurances

Primary Medical Insurance: _____

Subscriber ID #: _____

Group #: _____

Insurance Phone #: _____

Subscribers Name: _____

Subscribers DOB: _____

Secondary Medical Insurance: _____

Subscribers ID #: _____

Group # _____

Insurance Phone# _____

Dental Insurance: _____

Subscriber ID #: _____

Group #: _____

Subscriber ID #: _____

Insurance Phone #: _____

****Please attach a copy of patients drivers licence, all insurance cars, x rays, referrals, and pathology reports****

Primary Care Doctor & Dentist

Referred By: _____

_____

_____

Primary Care Doctor: _____

_____

_____

Dentist: _____

_____

_____