Patient: First _____ M.I. _____ Last _____

Date of Birth _____ ☐ Male ☐ Female Age _____ Weight _____ Occupation _____

Street _____ City _____ State _____ Zip _____

Main Tel. # _____ Other Tel.# _____ SS# _____

Dentist: _____ Referred By: _____

If under the age of 18, who will be responsible for your account? Name: _____ D.O.B. _____

Person Carrying Insurance: Name _____ D.O.B. _____ SS# _____
Please provide a copy of insurance card.

Reason for today's office visit: _____

Pharmacy Name: _____

Pharmacy Location: _____

Drug Allergies

Are you allergic to	Y	N	NOTES		Y	N	NOTES
Local Anesthetics				Sleep Aids			
Penicillin/Amoxicillin				Antidepressants			
Other Antibiotics				Iodine			
Demerol				Latex			
Lortab				Sulfa Drugs			
Codeine				Barbiturates, Valium			
Aspirin/ Ibuprofen				Anxiety Meds			

Other Drug Allergies?

Medications

Are you currently taking	Y	N	NOTES		Y	N	NOTES
Antibiotics				High Blood Pressure			
Blood Thinner/Aspirin				Antidepressants			
Diet Pills				Anxiety			
Insulin Meds				Nitroglycerin			
Pain Meds				Sleep Aids			
Cardiac Meds				Barbiturates, Valium			

Other Medications or Herbs?

Pregnancy

	Y	N	NOTES
Poss. Of Pregnancy?			
Are you nursing?			Obgyn Name:
Anticipated date of delivery?			Obgyn Phone:

NOTE: Antibiotics may alter the effectiveness of birth control meds. Consult your physician/obgyn for assistance regarding additional methods of birth control.

Health History

Have you had or do you currently have...	Y	N	NOTES	Have you had or do you currently have...	Y	N	NOTES
AIDS/Immune Deficiency				Thyroid Problems			
STD's				Chronic Fatigue			
Contagious Diseases				Epstein Barr/Mono			
Malignant Hyperthermia				Diabetes			
Bruise Easily				Low Blood Sugar			
Bleeding Tendency				Dialysis			
Blood Disorder				Kidney Trouble			
Hepatitis				Chest Pain/Angina			
Prosthetic Implants				Damaged Heart Valves/Stints			
Joint Disease				Cardiac Pacemaker			
Osteoporosis				Heart Attack			
Biophosphate Use				High Blood Pressure			
Pain/Clicking of Jaws/TMJ				Low Blood Pressure			
Bronchitis, Chronic				Stroke			
Emphysema				Mitral Valve Prolapse			
COPD				Heart Disease			
Cough/Asthma				Irregular Heart Beat			
Tuberculosis				Heart Murmur			
Other Lung Problems				Heart Surgery			
Cancer				Rheumatic Fever			
Radiation Therapy				Hay Fever/Sinus Prob.			
Chemotherapy				Tobacco Use			
Tumor or Abnormal Growth				Fibromyalgia			
Night Sweats				History of Alcohol Abuse			
Stomach Ulcers				History of Drug Abuse			
Convulsions, Epilepsy				Mental Health Disease			
Sleep Apnea/use CPAP				Under Pain Management			
Removable Dental Appliance							

All Medical records have been reviewed by physician: Date:

EMERGENCY CONTACT: _____ **PHONE:** _____ **RELATIONSHIP:** _____

MEDICAL INSURANCE: Our physicians do not participate in any medical networks.

MEDICARE/MEDICAID: We cannot file for Medicare or Medicaid. By utilizing any of our providers, you forfeit knowingly, your ability to be reimbursed by these insurers.

PAYMENT OPTIONS: Payment is expected when services are rendered. We accept all major credit cards, debit cards and cash.

I certify that I have read and I understand the questions above. I will not hold the doctor or staff responsible for patient errors or omissions made in the completion of this form. I acknowledge I have reviewed a current Privacy Practices for Gulf Coast Facial & Oral Surgery and consent for release of medical scheduling information on voicemail devices as necessary.

Signature: _____ Date: _____