COLLINS
ORAL & FACIAL SURGERY

Mitchell L. Collins, DDS, MD

General Patient Information

ANY PATIENT UNDER 18 MUST HAVE A PARENT/LEGAL GUARDIAN PRESENT ON THE DAY OF EVALUATION.

Date: _____

Prefix: _____ First: _____ MI: _____ Last: _____

Nickname: _____ Date of Birth: _____ Age: _____

Patient's Social Security #: _____ Home Ph #: _____ Cell Ph #: _____

Bus. Ph #: _____ E-mail: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient's Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: _____ Ph #: _____

REFERRAL INFORMATION:

You were referred by - First Name: _____ Last Name: _____

DOCTORS:

GENERAL DENTIST - First Name: _____ Last Name: _____

ORTHODONTIST - First Name: _____ Last Name: _____

FAMILY DOCTOR - First Name: _____ Last Name: _____

LIST ANY FAMILY MEMBERS SEEN BY DR. COLLINS:

1. _____ 3. _____

2. _____ 4. _____

Person Responsible for Bill: ☐ Patient ☐ Other: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Bus. Ph #: _____

E-mail: _____

Patient's relationship to responsible party: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other: _____

Do you have medical insurance? ☐ Yes ☐ No Dental insurance? ☐ Yes ☐ No

Insurance Company	Policyholder/Date of Birth	ID #	Ph #
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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Patient Name: _____

Date: _____

Health History

*Please bring a detailed list to your appointment if available.
*Please list any prescription medications, over-the-counter medications, and herbs you are currently taking:

Medication Name	Dosage/Frequency	Reason for Taking

Please list any previous surgeries, major injuries, or hospitalizations:

_____

_____

_____

_____

Please list any allergies to medications and/or foods:

_____

Please list any physicians you are currently seeing or have seen in the last 2 years:

_____

- Do you take or have you ever taken a drug for osteoporosis or cancer of the bone? ☐ Yes ☐ No
  If yes, please list all medications and years of use of each:
  _____
- Have you ever had chemotherapy for cancer treatment? ☐ Yes ☐ No
  Who was your oncologist?: _____
- Have you or a relative ever had a problem with anesthesia? ☐ Yes ☐ No
  If yes, explain: _____
- Have you ever smoked? ☐ Yes ☐ No
  How much? _____ When quit? _____

*Please place a checkmark to indicate any previous or current medical problems:

HEART PROBLEMS
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Stents
- ☐ Heart Valve Problem
- ☐ Heart Failure
- ☐ Atrial Fibrillation
- ☐ Heart Rhythm Problem
- ☐ Other: _____

LUNG PROBLEMS
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Recurrent Bronchitis or Pneumonia
- ☐ Other: _____

GENERAL MEDICAL
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ History of Cancer
  Specify: _____
- ☐ Thyroid Disease
- ☐ Stroke History
- ☐ Seizures
- ☐ Glaucoma
- ☐ Other: _____

BLOOD DISORDERS
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Low Platelets
- ☐ Other: _____

KIDNEY PROBLEMS
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Other: _____

GASTROINTESTINAL PROBLEMS
- ☐ Stomach Ulcers
- ☐ Reflux
- ☐ Liver Disease
- ☐ Hepatitis ☐ Other: _____

PSYCHIATRIC/ADDICTION
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Alcoholism
- ☐ Drug Use ☐ Other: _____

- Do you have any other medical problems that have not been covered? ☐ Yes ☐ No
  If yes, explain: _____

FEMALE PATIENTS:
- Could you be pregnant? ☐ Yes ☐ No
  When was your last menstrual period? _____
- Are your periods irregular? ☐ Yes ☐ No