MANOR ORAL AND MAXILLOFACIAL SURGERY
EDUARD I. MUNAROV, DDS

Today's Date _____
First Name _____ Last Name _____
Sex ___ Birth Date _____ Age____ Soc. Sec. # _____ email:_____
Address: Street _____ Apt.___ City _____ State:_____ Zip_____
Home Tel: _____ Cell _____
Occupation _____ Bus. Tel _____
Referring Dentist's Name_____ Orthodontist _____
Physician's Name and Address _____
Preferred Pharmacy _____ Tel. _____
Driver Lic. #_____
Employer_____ Tel _____
Emergency Contact: Name_____ Tel_____ Relationship_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

__ Self (If self, please skip this section) __ Spouse __ Father __ Mother Other: _____
First Name _____ Last Name _____ Relationship_____
Sex ___ Birth Date _____ Age____ Soc. Sec. # _____ email:_____
Address: Street _____ Apt.___ City _____ State:_____ Zip_____
Home Tel: _____ Cell _____
Occupation _____ Bus. Tel _____

INSURANCE INFORMATION:

Student: __Full Time __Part Time __Not School Name and Address:_____
Marital Status: __Married __Single __Divorced __Widow __Legally Separated
Employement: __Full Time __Part Time __Retired __Unemployed

PRIMARY DENTAL INSURANCE COMPANY:

Employer: _____
Bus Address: _____
_____
Bus Tel: _____ Plan:_____
Ins Co Name _____ ID_____
Address_____
_____
Tel: _____ Group Name_____
Group #_____
Insured Party Name _____
Relation_____ Birth Date_____Sex: _M _F
Soc Sec# _____ Tel: _____
Address:_____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: _____
Bus Address: _____
_____
Bus Tel: _____ Plan:_____
Ins Co Name _____ ID_____
Address_____
_____
Tel: _____ Group Name_____
Group #_____
Insured Party Name _____
Relation_____ Birth Date_____Sex: _M _F
Soc Sec# _____ Tel: _____
Address:_____

SECONDARY DENTAL INSURANCE COMPANY:

Employer: _____
Bus Address: _____
_____
Bus Tel: _____ Plan:_____
Ins Co Name _____ ID_____
Address_____
_____
Tel: _____ Group Name_____
Group #_____
Insured Party Name _____
Relation_____ Birth Date_____Sex: _M _F
Soc Sec# _____ Tel: _____
Address:_____

SECONDARY MEDICAL INSURANCE COMPANY:

Employer: _____
Bus Address: _____
_____
Bus Tel: _____ Plan:_____
Ins Co Name _____ ID_____
Address_____
_____
Tel: _____ Group Name_____
Group #_____
Insured Party Name _____
Relation_____ Birth Date_____Sex: _M _F
Soc Sec# _____ Tel: _____
Address:_____

HEALTH HISTORY:

PLEASE ANSWER ALL QUESTIONS. ALL RESPONSES ARE KEPT CONFIDENTIAL.

Height_____ Weight_____

Reason for today's visit? _____

1. Are you in good health? Yes No
2. Have there been any changes in your general health in the past year? Yes No
3. Date of you last physical exam? _____
4. Are you under a physician's care for a particular problem? Yes No
5. Have you had any illness, operations, or hospitalizations? Yes No
   If so, describe:_____
6. Do you have a prosthetic joint/ implant? If so, where_____
7. Have you had a heart valve replacement or congenital heart defect? Yes No
8. Have you, or a family member, had any reaction to general anesthesia? Yes No

DO YOU HAVE OR HAVE YOU EVER HAD:

9. Rheumatic fever?	Yes	No
10. damaged heart valve/ mitral valve prolapse?	Yes	No
11. Heart disease (heart attack, coronary artery disease, palpitations, heart surgery (bypass), pacemaker, congenital heart defect?	Yes	No
12. Angina?	Yes	No
13. Stroke?	Yes	No
14. High or Low blood pressure?	Yes	No
15. Lung disease (asthma, emphysema, chronic or severe cough, pneumonia, tuberculosis, bronchitis, shortness of breath, COPD)?	Yes	No
16. Implants placed anywhere in your body (heart valve, hip, knee)?	Yes	No
17. Neurologic disorders (convulsions, epilepsy, seizures, fainting, dizziness, stroke)?	Yes	No
18. Liver disease (Jaundice, hepatitis)?	Yes	No
19. Blood Disease (anemia, bleeding tendency, blood transfusion bruise easily)?	Yes	No
20. Kidney disease?	Yes	No
21. Diabetes?	Yes	No
22. Thyroid disease (goiter)?	Yes	No
23. Recurrent infections or mouth sores?	Yes	No
24. Stomach ulcers, Colitis or arthritis?	Yes	No
25. Glaucoma?	Yes	No
26. Cancer? What type?_____	Yes	No
27. Radiation or Chemotherapy for cancer? Which area for radiation?	Yes	No

28. Osteoporosis/ Osteopenia	Yes	No
29. Kidney disorder?	Yes	No
30. Dialysis?	Yes	No
31. Temporomandibular Joint (TMJ) problems?	Yes	No
32. Sinus or Nasal problems?	Yes	No
33. Any drug disease or transplant operation that has suppressed your immune system?	Yes	No
34. History of alcohol abuse?	Yes	No
35. History of drug abuse?	Yes	No
36. Mental health problems/ anxiety/ depression?	Yes	No
37. An adverse reaction to anesthesia?	Yes	No
38. Do you smoke? If so, how many packs per day_____	Yes	No

Women:

Are you pregnant or planning pregnancy? Yes No

Expected delivery date _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

Note: Antibiotics, such as penicillin, may alter effectiveness of birth control pills. Consult your physician or OBGYN for assistance regarding other methods of birth control

MEDICATION HISTORY:

Are you taking any medications, drugs, pills?	Yes	No
Are you on any blood thinners such as Coumadin, Plavix, Aspirin, Pradexa, Xarelto, Fish Oil	Yes	No
Have you ever taken or are you taking any "bone strengthening" medications such as bisphosphonates or Donusomab. (Ie: Fosamax, Boniva, Actonel, Zometa, Aredia, Prolia, Xgeva)	Yes	No

Please list any medications you are currently taking:

Medication	Dosage	Frequency

DO YOU HAVE ALLERGIES TO:

Local anesthestic (novacaine/ lidocaine)?	Yes	No
Penicillin and/or Amoxicillin?	Yes	No
Other antibiotics?	Yes	No
Sulfa drugs?	Yes	No
Aspirin?	Yes	No
Codeine or other narcotics?	Yes	No
Latex?	Yes	No
Soy?	Yes	No
Eggs/ yolk?	Yes	No
Sulfites?	Yes	No
Any other allergies? Please List:_____ _____ _____	Yes	No

Is there another condition(s) not listed above? ____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? If yes, indicate the relationship.

Diabetes? Yes No Relationship _____ Cancer? Yes No Relationship _____

Heart disease? Yes No Relationship _____ Bleeding problems? Yes No Relationship _____

Tumors? Yes No Relationship _____ Lung disease? Yes No Relationship _____

Sleep Apnea? Yes No Relationship _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____ _____

Signature of patient (Parent or Guardian if Minor) Date Reviewed by and Date

Authorization

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment and treatment.

_____ _____ _____

Signature of patient (Parent or Guardian if Minor) Date Doctor and Date