Bluegrass Oral & Maxillofacial Surgery

Wm. Jason Barker, D.M.D.
3080 Harrodsburg Road, Suite 275 • Lexington, KY 40503

CONFIDENTIAL

Patient Medical History Form

DATE_____

NAME OF PATIENT_____ SEX: □ M □ F MARITAL STATUS: □ S □ M □ D □ W

HOME ADDRESS _____ HOME PHONE _____

CITY_____ STATE _____ ZIP _____ CELL PHONE _____

SOCIAL SECURITY #_____ AGE_____ DATE OF BIRTH _____

HEIGHT_____ WEIGHT_____

FULL TIME STUDENT □ YES □ NO SCHOOL _____

EMPLOYER_____ EMPLOYED: □ FT □ PT

EMPLOYER ADDRESS_____ WORK PHONE _____

CITY_____ STATE _____ ZIP _____

PHYSICIAN_____ DENTIST_____ ORTHODONTIST_____

REFERRED BY_____ ARE YOU HERE AS A RESULT OF AN ACCIDENT? □ YES □ NO

HAS A FAMILY MEMBER BEEN TREATED BY DR. BARKER? □ YES □ NO NAME(S): _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE_____

GUARANTOR

(PLEASE COMPLETE IF PERSON RESPONSIBLE FOR PAYMENT / ADULT IS OTHER THAN PATIENT)

Marital Status: □ S □ M □ D □ W

Name:_____ Date of Birth: _____

Relation to patient: _____ SS# _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone_____

Employer: _____ Employer's Address: _____

INSURANCE INFORMATION

Medical

Insurance Company: _____

Address: _____

Policy Holder/Insured Party: _____

Relationship to Patient: _____

Insured ID# _____

Policy Holder/Insured's Date of Birth: _____

Group # or Company Name: _____

Policy Holder/Insured's SS# _____

Dental

Insurance Company: _____

Address: _____

Policy Holder/Insured Party: _____

Relationship to Patient: _____

Insured ID# _____

Policy Holder/Insured's Date of Birth: _____

Group # or Company Name: _____

Policy Holder/Insured's SS# _____

REASON FOR VISIT TODAY _____

CURRENT MEDICATIONS, DRUGS, PILLS, HERBAL MEDICINES, BLOOD THINNERS _____

_____

_____

ALLERGIES TO DRUGS AND/OR ANESTHETICS (SOY, EGGS, SULFITES) _____

_____

WOMEN: ARE YOU PREGNANT? □ Y □ N NURSING? □ Y □ N ARE YOU TAKING BIRTH CONTROL PILLS? □ Y □ N

HAVE YOU EVER TAKEN MEDICINE FOR OSTEOPOROSIS? □ Y □ N _____

HAVE YOU EVER HAD EMOTIONAL OR NERVOUS CONDITIONS REQUIRING TREATMENT? □ Y □ N

PREVIOUS SURGERY OR GENERAL ANESTHESIA (PUT TO SLEEP): _____

_____

HAVE YOU EVER HAD AN UNUSUAL REACTION TO BEING PUT TO SLEEP? □ Y □ N

HEART PROBLEMS	□ Y □ N	ASTHMA OR EMPHYSEMA	□ Y □ N
ARTIFICIAL HEART VALVE	□ Y □ N	TUBERCULOSIS (TB)	□ Y □ N
CHEST PAIN/ ANGINA	□ Y □ N	KIDNEY OR LIVER DISEASE	□ Y □ N
CARDIAC PACEMAKER	□ Y □ N	VENEREAL DISEASE	□ Y □ N
HIGH BLOOD PRESSURE	□ Y □ N	ULCERS	□ Y □ N
STROKE / TIA	□ Y □ N	HIV / AIDS	□ Y □ N
BLEEDING DISORDERS	□ Y □ N	AUTOIMMUNE DISORDER	□ Y □ N
ANEMIA	□ Y □ N	THYROID DISEASE	□ Y □ N
DIABETES	□ Y □ N	RADIATION / CHEMOTHERAPY	□ Y □ N
HEPATITIS	□ Y □ N	MALIGNANT HYPERTHERMIA	□ Y □ N
ARTIFICIAL JOINT	□ Y □ N	OBSTRUCTIVE SLEEP APNEA	□ Y □ N
SEIZURES	□ Y □ N	USE OF A C-PAP	□ Y □ N

DO YOU SMOKE PRESENTLY?
□ Y □ N

YEARS SMOKED? _____
PACKS PER DAY? _____

HAVE YOU EVER SMOKED?
□ Y □ N

IF YES, WHEN DID YOU QUIT?
_____

DO YOU NOW USE SMOKELESS TOBACCO PRODUCTS?
□ Y □ N

IS THERE ANY CONDITION CONCERNING YOUR HEALTH THAT THE DOCTOR SHOULD BE TOLD ABOUT? □ Y □ N

(IF YES, DESCRIBE):_____

DO YOU WISH TO SPEAK TO THE DOCTOR PRIVATELY ABOUT ANYTHING? □ Y □ N

IS THERE A FAMILY HISTORY OF:	ANESTHETIC PROBLEMS	□ Y □ N	CANCER	□ Y □ N
	DIABETES	□ Y □ N	HEART DISEASE	□ Y □ N

I HAVE COMPLETED THIS FORM AND CERTIFY THAT I AM THE PATIENT, OR THE LEGAL GUARDIAN OF THE PATIENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED, AND THAT THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Signature (if over 18)_____ Printed Name_____ Date _____

Physician Signature_____ (Wm. Jason Barker, D.M.D.) Date _____

FOR FUTURE USE ONLY: It has been 3 months since my last visit; I attest that I have reviewed my medical history and made any required changes.

Patient Signature _____ Printed Name: _____ Date _____

Patient Signature _____Printed Name: _____ Date _____