New Canaan & Westport Oral & Maxillofacial Surgery
Philip F. Pacelli, D.M.D., M.D.

Today's Date: ___/___/___ PLEASE PRINT CLEARLY

Patient Information

Name: Mr. Ms. Mrs. Miss. Dr _____ **Date of Birth:** _____/_____/_____ **Age:** _____

Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Home Phone:_____ **Cellular:**_____ **Email:**_____

(IF PATIENT IS A MINOR) **Parent, Legal Guardian, or Primary Insurance holder:**_____

Home Phone:_____ **Cellular:**_____ **Work:**_____

Date of Birth: _____/_____/_____ **Social Security Number:** _____

Pharmacy _____

Primary Care Physician: _____ Last Physical Exam:_____ **Dentist:**_____

HEALTH HISTORY:

1) Please List any Physicians that you are currently seeing with a list of medications that you are currently taking or HAVE taken in the past:

Physician and their specialty:	What is being treated:	Medications prescribed by this physician:

2) Any medications or supplements not listed above? Yes No If Yes Explain

_____

3) Do you or HAVE you EVER seen a **cardiologist** for any reason? Yes No

Name and phone number of your **cardiologist** and reason_____

4) Do you have to **Pre-Medicate** **with antibiotics before dental treatments due to heart valve issues or artificial joint replacement?** Yes No

Why do you pre-medicate? Hip Knee Shoulder Heart
What antibiotic and dosage do you take?_____

5) Have you been instructed by a physician or **cardiologist** to consume daily **blood thinner** medicine? Yes No
If yes, please circle one of the following: **ASPIRIN/ COUMADIN/ PLAVIX/ ECOTRIN/ PLETAL/ ELIQUIS**
Dosage and Prescriber_____

6) Are you currently taking or have you taken **Osteoporosis** medications such as **FOSOMAX, ACTONAL, BONIVA, RECLAST or ZOMETA**? YES NO
If yes, how long and when? _____

7) Are you currently taking any medications to treat **cancer** or radiation treatment? Yes No
If yes what medication? _____

8) Do you have any Allergies to Latex or to any Medications, Peanuts, Egg whites, or soy? Yes No
If yes please list:_____

9) Do you smoke or use any **tobacco** products? (DIP/CHEW)? YES No
If yes, how much daily? _____

10) Do you consume **alcohol**? YES NO
If yes, how much/how often? _____

11) Have you ever sought professional care for **drug or alcohol dependency**? Yes No

12) Have you ever sought professional care for any type of **emotional disorder**? YES NO
If yes, what medication(s) were prescribed? _____

13) Have you ever had any adverse reactions to any dental treatments? YES NO
If yes, what was the reaction? _____

14) Any **OTHER** medical history information not mentioned above?_____

_____

I certify that I both read and comprehend the English language. I have read and understood the above listed information. I have answered all questions honestly and to the best of my knowledge. I understand that these questions were to be answered truthfully to best assist Dr.'s Pacelli in providing me with the best possible care.

SIGNED: _____DATE: _____

WOMEN ONLY:

Are you currently pregnant or planning a pregnancy? YES NO

Are you currently taking oral contraceptives? YES NO