New Canaan Oral & Maxillofacial Surgery, P.C.
Philip F. Pacelli D.M.D., M.D.
Steven E. Smullin D.M.D., M.D.
166 Cherry Street, SUITE A
New Canaan, CT 06840

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

Patient Information: (Please circle) Mr. Ms. Mrs. Miss. Dr.
Patient Name: _____**Date of Birth**: _____/_____/_____ **Age:** _____
Address: _____**City**:_____**State**:_____**ZIP**:_____
Home Phone: _____**Cellular**:_____**Work**:_____
EMAIL:_____@_____ **STUDENT STATUS**: Full Time or Part Time
Pharmacy _____
Physician: _____**Dentist**: _____ **Referral**: _____
Reason for today's visit: _____

(IF PATIENT IS A MINOR) **Patients Parent or Legal Guardian Name:** _____
Home Phone: _____**Cellular**:_____**Work**:_____
Date of Birth: _____/_____/_____**Social Security Number**: _____

HEALTH HISTORY:
1) Date of your last physical exam? _____

2) Have there been any changes in your health in the past year? Yes No If Yes Explain
_____

3) Are you under a physician's care for anything? Yes No If Yes Explain
_____

4) Have you been instructed by a physician to **pre-medicate with antibiotics before dental treatments due to heart valve issues or artificial joint replacement?** Yes No Why do you pre-medicate? _____

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/ HERBAL MEDICINE**

6) Do you currently or have you ever had any of the following?

Rheumatic Fever	Cancer	Joint Replacement	Peptic Ulcers or Colitis
Rheumatic Heart Disease	Radiation For Cancer	Organ Transplant	Arthritis
Congenital Heart Disease	Hepatitis A B C	Tuberculosis	Sinus Problems
Mitral Valve Prolapse	Jaundice	COPD	Fever Blisters
Coronary Artery Disease	Epilepsy	Asthma	Clicking Jaw Joint or Sounds
Stroke or Heart Attack	Convulsions or Seizures	Emphysema	Grinding of Teeth
Heart Palpitations	HIV or AIDS	High Blood Pressure	Facial Neuralgia
Heart Surgery	Kidney/ Liver Disease	Low Blood Pressure	Fibro Myalgia
Pacemaker or Stents	Diabetes Type 1 or 2	Cholesterol Low/High	Psychiatric Treatment
Atrial Defect	Bleeding Disorder	Thyroid Disease	Nervous Disorder
Angina	Anemia	Glaucoma	Fainting or Dizziness
Heart Murmur	Blood Transfusion	Stomach Problem	Drug or Alcohol Abuse

7) Are you currently taking any of the following medication?

Stomach Ulcer Drugs	Steroids	Antibiotics	Vitamin Supplement
Thyroid Drugs	Psychiatric Drugs	Nitroglycerin	Acne Medication
High Blood Pressure Drugs	Irregular Heart Beat Drugs	Chemotherapy Drugs	NSAIDS

8) Are you currently taking Osteoporosis medications such as **FOSOMAX, ACTONAL, BONIVA, RECLAST or ZOMETA**? YES NO
If yes, how long? _____Years or _____Months

9) Are you currently taking Diabetes medications such as **INSULIN, METAFORMIN, or JANUVIA**? YES or NO

10) Are you currently taking any medications to treat cancer? Yes NO If yes what medication? _____

11) Have you ever had radiation treatment to treat cancer? YES NO If yes, what specific area? _____

12) Are you allergic to any of the following medications or items?

ANTIBIOTICS:	**NARCOTICS:**	**NSAIDS**	**SEDATIVES**
Penicillin, Amoxicillin , Augmentin	Codeine	Advil, Motrin, Ibuprofen, Nuprin (NSAIDS)	*Benzodiazepines:* Valium,
Clyndamycin,Cleocin, Vancomycin	Morphine	Aleve, Naproxen	Versed, Midazolam, Diazepam
Cephalosporins, Keflex	Vicodin	Tylenol, Acetaminophen	Xanex
Tetracycline, Doxycycline, Minocycline	Percocet	Celebrex, Vioxx, Voltaren	Clonazepam,Klonopin
Sulfa	Percodan	Acetylsalicylic Acid	*Barbiturates:* amobarbital,
Omnicef	Fentanyl	Mobic, Bextra	thiopental, pentobarbital
Zithromax,Biaxin, Erythromycin	**General Anesthesia**	Excedrin,Bufferin, Bayer,	**Dyes or Iodine**
Latex	**Local Anesthesia**	Ecotrin, Aspirin	**Any other Medication**

13) Do you smoke? YES NO If yes, how much daily? _____

14) Do you use any tobacco products? (DIP/CHEW)YES NO If yes, what product? _____

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

16) Have you ever sought professional care for drug or alcohol dependency? Yes NO

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

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

19) Do you have any disease or condition not listed? YES NO If yes, _____

WOMEN ONLY:

Are you currently pregnant or planning a pregnancy? YES NO

Are you currently taking oral contraceptives? YES NO

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 and Smullin in providing me with the best possible care.

SIGNED: _____DATE: _____