



MACON ORAL
AND MAXILLOFACIAL
SURGERY, P. C.

MEDICAL HISTORY FORM

Name: _____ Date: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____ BP: _____ HR: _____ T: _____

SaO2: _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? Yes No
2. Has there been any change in your health in the past year? Yes No
3. My last physical exam was on _____ / _____ / _____
4. Are you now under the care of a physician? Yes No
If so, for what condition? _____
5. The name and address of my physician is: _____

6. Have you had any serious illness, significant operation or hospitalization within the past 5 years? Yes No
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills Yes No
If so, please list _____
8. Do you have or have you had any of the following diseases or problems?
 - a. Damaged heart valves, artificial valves or heart murmur Yes No
 - b. Rheumatic Heart Disease Yes No
 - c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis
or any other heart condition Yes No
 1. Chest pain upon exertion? Yes No
 2. Shortness of breath after mild exercise? Yes No
 3. Do your ankles swell? Yes No
 - d. Allergies Yes No
 - e. Sinus trouble Yes No
 - f. Asthma Yes No
 - g. Fainting spells Yes No
 - h. Diabetes Yes No
 - i. Hepatitis, jaundice or liver disease Yes No
 - j. Frequent or recurring mouth sores Yes No
 - k. Thyroid problems Yes No
 - l. Respiratory problems, emphysema, bronchitis, etc. Yes No
 - m. Arthritis or painful, swollen joints including jaw joint (TMJ) Yes No
 - n. Stomach ulcer or hyperacidity Yes No
 - o. Kidney trouble Yes No
 - p. Tuberculosis Yes No
 - q. Persistent cough or cough that produces blood Yes No
 - r. Persistent swollen neck glands Yes No
 - s. Low blood pressure Yes No
 - t. Epilepsy or neurological disorder (seizures) Yes No
 - u. Are you taking vitamins or homeopathic remedies Yes No
 - v. Cancer. What kind of cancer and how treated? Yes No
 - w. Any disease, drug or transplant operation that has depressed your immune system Yes No
 - x. HIV or AIDS? Yes No
 - y. Hepatitis? Which kind? How treated? Yes No
9. Have you had abnormal bleeding? Yes No
10. Do you have any blood disorder such as anemia? Yes No
11. Have you ever had treatment for a tumor or growth? Yes No
12. Are you allergic to or have you had a reaction to and describe what happened:
 - a. Local anesthetics Yes No
 - b. Penicillin or antibiotics Yes No
 - c. Sulfa drugs Yes No
 - d. Barbiturates or sleeping pills Yes No
 - e. Aspirin Yes No
 - f. Iodine Yes No
 - g. Codeine or other narcotics Yes No

- h. Latex or rubber products..... Yes No
- i. Other..... Yes No
- 13. Have you had any serious trouble associated with previous dental or surgical treatment..... Yes No
If so, explain: _____
- 14. Do you have any other condition or disease you think the doctor should know about?..... Yes No
If so, explain: _____
- 15. Are you wearing contact lenses?..... Yes No
- 16. Are you wearing removable dental appliances..... Yes No
- 17. Do you wish to talk with the doctor privately about anything..... Yes No
- 18. Do you use tobacco? How much? Yes No
- 19. Do you drink alcohol? How much? Yes No
- 20. Do you use any illicit recreational drugs? Which ones? When was last time? (This information will not be used for legal purposes, but is very important as it could affect anesthesia and surgery profoundly.) Yes No
- 21. Have you ever had any kind of anesthesia? What kind? What for? Any problems?..... Yes No

Women

- 18. Are you pregnant or trying to become pregnant Yes No
- 19. Do you have problems associated with your menstrual period?..... Yes No
- 20. Are you nursing?..... Yes No
- 21. Are you taking birth control pills?..... Yes No

Chief Complaint: _____

I certify that I have read and understand the 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 surgeon, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Patient's Signature _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Surgery management considerations: _____

Date: _____ Doctor's Signature: _____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT - INSURANCE INFORMATION

Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.

Patient's Name: _____ Today's Date _____

Sex: _____ Age: _____ Birth Date: _____ Soc. Sec. # _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Birth Date: _____

Responsible Party's Name: _____ DOB: _____

Soc. Sec. # _____ Relationship to Insured: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ DOB: _____

Name of Insurance Plan: _____ Group Number: _____

Physician: _____ Referring Dentist: _____

Orthodontist: _____

Reason for Visit: _____

Family members who have been patients here: _____

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Patient's Name _____

Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

I hereby authorize Dr. W. Rob McCormack and staff to perform the following procedure:

and to administer the anesthesia I have chosen, which is:

- Local Anesthesia
- Local Anesthesia with Oral Premedication
- Local Anesthesia with Intravenous Sedation
- General Anesthesia

Other treatment options: _____

- _____ 1. I understand that there are known consequences of surgery and the administration of drugs and anesthetics which include (but are not limited to): pain and discomfort, swelling, bleeding, bruising, and infection. Changes in the bite or restricted mouth opening secondary to stress on the jaw joint (TMJ) may occur. There is also the possibility of injury to adjacent teeth or other tissues of the face or mouth, bone/jaw fractures, delayed healing, dry socket, or unexpected drug reactions or allergies.
- _____ 2. With tooth extraction, I understand that there may be unexpected damage to adjacent teeth or fillings, sharp ridges or bone splinters that may require later surgery to smooth or remove, dry socket which will require additional care, or small fragments of tooth root which may be left in place to avoid damage to vital structures such as nerves or sinus.
- _____ 3. Lower tooth roots may be very close to the nerve and surgery may result in pain or a numb feeling of the chin, lip, cheek, gums, teeth or tongue lasting for weeks, months, or may rarely be permanent. On upper teeth where roots are close to the sinus, a sinus infection may develop, a root tip may enter the sinus and/or an opening from the mouth to the sinus may occur which could require later medication or surgery.
- _____ 4. **ANESTHETIC RISKS** include: discomfort, swelling, bruising, infection, and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) which may cause prolonged discomfort and/or disability, and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. Intravenous anesthesia is a serious medical procedure and, although considered safe, carries with it the rare risks of heart irregularities, heart attack, stroke, brain damage or death.

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- _____ 5. **YOUR OBLIGATIONS IF IV ANESTHESIA IS USED**
- A. Because anesthetic medications cause prolonged drowsiness, you **MUST** be accompanied by a responsible adult to drive you home and stay with you until you are recovered sufficiently to care for yourself. This may be up to 24 hours.
 - B. During recovery time (24 hours) you should not drive, operate complicated machinery or devices, or make important decisions such as signing documents, etc.
 - C. You must have a completely empty stomach. **IT IS VITAL THAT YOU HAVE NOTHING TO EAT OR DRINK FOR EIGHT (8) HOURS PRIOR TO YOUR ANESTHETIC. TO DO OTHERWISE MAY BE LIFE-THREATENING!**
 - D. **However**, it is important that you take any regular medications (high blood pressure, antibiotics, etc.) or medications provided by this office, **using only a small sip of water.**
- _____ 6. I understand that no guarantee can be promised, and I give my free voluntary consent for treatment. I realize that my doctor may discover conditions requiring different surgery from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

INFORMATION FOR FEMALE PATIENTS

- _____ 1. I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my personal physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my personal physician that I can return to the use of oral birth control pills.

CONSENT

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved of the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian's) Signature Date

Doctor's Signature Date

Witness' Signature Date

Macon Oral and Maxillofacial Surgery
112 Arkwright Landing
Macon, Georgia 31210

Notice of Privacy Practice For Protected Health Information
Effective Date January 1, 2004

I, _____, hereby acknowledge that I received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature/Guardian

Date