Chris Kinney DDS
ORAL + MAXILLOFACIAL SURGERY

38th Street Professional Park • 3825 Fairview Dr. • Anderson, IN 46013 • (765) 649-8118

Date _____

**PATIENT INFORMATION RECORD** *(PLEASE PRINT ANSWERS)*

Name _____ Preferred Name _____

Address _____ Phone _____

City _____ State _____ Zip _____

S.S. # _____ Age _____ Birthdate _____

Sex _____ Weight _____ Martial Status ❑ Single ❑ Married ❑ Widowed

Full Time Student YES NO

Physician _____ Phone _____

Dentist _____ Phone _____

Occupation _____ Employer _____ Phone _____

Nearest Relative Not Living With You _____ Phone _____

**RESPONSIBLE PARTY**

Person Responsible for Payment _____

Relationship _____ S.S. # _____

Phone _____ Work Phone _____

Address *(if different from above)* _____

**INSURANCE INFORMATION**

Name of Insured _____

S.S. # _____ Birthdate _____ Employer _____

Dental Ins. Co. _____ Medical Ins. Co. _____

Do you have additional insurance? YES NO If yes, complete the following:

Name of Insured _____

S.S. # _____ Birthdate _____ Employer _____

Dental Ins. Co. _____ Medical Ins. Co. _____

## CORE MEDICAL HISTORY

1. Are you now or have been under the care of a physician during the last 2 years? ..... YES NO

   If yes, for what reason _____

2. Are you taking any medicine or drugs at the present time? ..... YES NO

   If yes, please list _____

   _____

3. Are you allergic to any medicine or drugs? ..... YES NO

   If yes, please list _____

   _____

4. Do you have a cold, sore throat, or upper respiratory illness now? ..... YES NO
5. Do you get short of breath or have chest pain? ..... YES NO
6. Have you ever had excessive bleeding from wounds or extractions? ..... YES NO
7. Have you ever taken cortisone or steroids? ..... YES NO
8. Have you been treated for osteoporosis? ..... YES NO
9. Do you use non prescribed drugs or have been treated for drug abuse? ..... YES NO
10. Do you smoke or use tobacco products? ..... YES NO
11. Have you had a general anesthetic in the past? ..... YES NO
12. What is your oral surgical problem? .....☐
13. Please check yes or no to all items listed below:

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Asthma | ☐ | ☐ | Anemia | ☐ | ☐ | Radiation Treatment | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | Stomach Problem | ☐ | ☐ | High Blood Pressure | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Stroke | ☐ | ☐ | Syphilis or Venereal Disease | ☐ | ☐ | Psychiatric Disorder | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Seizures (Epilepsy) | ☐ | ☐ | Hepatitis (Yellow Jaundice) | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Cancer | ☐ | ☐ | Implant of any kind | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | AIDS / H.I.V. | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Fainting Spells | ☐ | ☐ | TMJ Pain | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | Sinus Problems | ☐ | ☐ | | | |

14. List any health problem not covered above _____
15. Have you been hospitalized in the past 5 years? ..... YES NO

    If yes, for what reason? _____
16. (Women) Are you pregnant? YES NO If so, how many months? _____ Dr. _____
17. Have you had anything to eat or drink during the past 6 hours? ..... YES NO
18. If this office visit is a result of an accident, please give details _____

    _____

    _____

Signature: _____ Date: _____