PRACTICE LIMITED TO
ORAL AND MAXILLOFACIAL
SURGERY

MAURICE R. CROWLEY, D.M.D.
PROFESSIONAL ARTS BUILDING, SUITE 402
NEW ALBANY, INDIANA 47150

AREA CODE 812
TELEPHONE 945-2760
FAX 945-2760

NAME _____ DATE _____
ADDRESS _____ TELEPHONE _____
CITY _____ ZIP _____

HEALTH QUESTIONAIRE

AGE _____ BIRTH DATE _____ SEX _____

		YES	NO	REMARKS
1.	WHAT IS YOUR PRESENT HEALTH STATUS? _____			
2.	HAVE YOU RECENTLY BEEN UNDER MEDICAL TREATMENT?	□	□	

3. HAS A PHYSICIAN EVER INFORMED YOU THAT YOU HAD:

	YES	NO		YES	NO		YES	NO
	YES	**NO**	**HEPATITIS**	□	□	**DISEASE OF:**		
A HEART AILMENT	□	□	**TMJ PROBLEMS**	□	□	**EYES, EARS, NOSE, THROAT**	□	□
RHEUMATIC FEVER	□	□	**COMMUNICABLE DISEASE**	□	□	**KIDNEY DISEASE**	□	□
HIGH BLOOD PRESSURE	□	□	**BLOOD DISEASE**	□	□	**THYROID DISEASE**	□	□
LUNG DISEASE	□	□	**DIABETES**	□	□	**TB**	□	□
ASTHMA OR BRONCHITIS	□	□	**GLAUCOMA**	□	□	**ARTHRITIS**	□	□
LIVER DISEASE	□	□	**STOMACH OR**			**TUMORS OR GROWTHS**	□	□
IMMUNE SUPPRESSING DISEASE	□	□	**INTESTINAL DISEASE**	□	□	**NERVOUS DISORDERS**	□	□

4.	HAVE YOU HAD ANY MAJOR OPERATIONS? _____	□	□
5.	HAVE YOU HAD ANY BLEEDING OR HEALING PROBLEMS? _____	□	□
6.	ARE YOU PRESENTLY TAKING ANY MEDICATION? _____	□	□
	ANTIBIOTIC? _____	□	□
7.	ARE YOU ALLERGIC TO ANY FOODS OR DRUGS? _____	□	□
	PENICILLIN? _____	□	□
8.	HAVE YOU HAD ANY DIFFICULTIES WITH GENERAL ANESTHESIA? _____	□	□
	LOCAL ANESTHESIA? _____	□	□
9.	HAVE YOU EVER HAD RADIATION THERAPY? _____	□	□
10.	DO YOU WEAR CONTACT LENSES? _____	□	□
11.	ARE YOU PREGNANT? _____	□	□
12.	LAST INTAKE OF FOOD OR LIQUID? _____ TIME? _____	□	□
13.	DO YOU SMOKE? _____	□	□
14.	DO YOU HAVE A HEART VALVE REPLACEMENT OR VASCULAR GRAFT? _____	□	□
15.	DO YOU HAVE A PROSTHETIC JOINT? _____	□	□
16.	DO YOU HAVE DAMAGED HEART VALVES/MITRAL VALVE PROLAPSE? _____	□	□
17.	HAVE YOU HAD A STROKE? _____	□	□
18.	HAVE YOU HAD AN ORGAN TRANSPLANT? _____	□	□

PERSONAL INFORMATION

PATIENT: _____ PERSON RESPONSIBLE: _____

SOC. SEC. NO.: _____ SOC. SEC. NO.: _____

EMPLOYER: _____ OCCUPATION: _____ EMPLOYER: _____

PHONE NUMBER: _____ PHONE NUMBER: _____

INSURED PARTY: _____ INSURED SS#: _____ INSURED DOB: _____

EMPLOYER: _____ DENTAL INS.: _____ MEDICAL INS.: _____

FAMILY DENTIST: _____ FAMILY PHYSICIAN: _____

REFERRED BY: _____

HAVE YOU OR ANY OF YOUR IMMEDIATE FAMILY BEEN SEEN IN THIS OFFICE BEFORE:

TO DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT WHO ACCOMPANIES THE CHILD FOR CARE WILL BE HELD RESPONSIBLE FOR ALL BILLS.

IF YOUR INSURANCE CARRIER HAS NOT MADE FULL PAYMENT TO THIS OFFICE WITHIN THE SIXTY DAY PERIOD AFTER TREATMENT, THE TOTAL FEE WILL THEN BE DUE IN FULL BY YOU. IN THE EVENT THAT YOU DO NOT RECEIVE THE BENEFITS TO WHICH YOU FEEL THAT YOU ARE ENTITLED FROM YOUR INSURANCE COMPANY, WE SUGGEST THAT YOU CONTACT YOUR INSURANCE REPRESENTATIVE, YOUR UNION ANGENT, OR YOUR LOCAL CONSUMER PROTECTION AGENCY.
IF YOU HAVE MORE QUESTIONS CONCERNING YOUR ORAL SURGICAL CARE AND INSURANCE COVERAGE, PLEASE ASK THE DOCTOR FOR MORE INFORMATION.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICY STATEMENT.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

FORM 135827 R/08/09 ITEM 8101