ABINGTON ORAL AND MAXILLOFACIAL SURGERY, P.C.

Today's Date ____/____/____

PATIENT'S NAME	SEX	AGE	BIRTH DATE	HOME PHONE BUS. PHONE
ADDRESS	CITY		STATE	ZIP CODE
OCCUPATION	SOC. SECURITY #		SPOUSE/PARENT	
WHO IS RESPONSIBLE FOR THIS ACCOUNT?	SOC. SECURITY #		DATE OF BIRTH	
DENTAL INSURANCE	MEDICAL INSURANCE			
PHYSICIAN'S NAME	DENTIST'S NAME		ORTHODONTIST'S NAME (if applicable)	
REFERRED BY	REASON FOR VISIT			

Please answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Are you allergic to any medications? ..... Y N

   If yes, Please list: _____
4. Are you taking any medication? ..... Y N (including aspirin products)

   If yes, Please list: _____
5. Have you had any operations, serious illness or hospitalizations? ..... Y N

   If yes, Please list: _____
6. WOMEN:
   - Are you pregnant or planning pregnancy? ..... Y N
   - Are you taking Birth Control? ..... Y N
   - Are you taking Hormone replacements? ..... Y N
7. Do you smoke? ..... Y N
8. Have you ever had Radiation therapy? ... Y N
9. Have you ever had chemotherapy? ..... Y N
10. Do you have problems with your jaw joints? ..... Y N
11. Do you have implants placed anywhere on your body (heart valve, hip, knee)? .... Y N
12. Do you have or have you ever had:
    - a. Rheumatic Fever? ..... Y N
    - b. Heart Disease? ..... Y N
    - c. Heart Murmur? ..... Y N
    - d. High Blood Pressure? ..... Y N
    - e. Pace Maker? ..... Y N
    - f. Heart Attack? ..... Y N
    - g. Angina? ..... Y N
    - h. Stroke? ..... Y N
    - i. Heart Surgery? ..... Y N
    - j. Diabetes? ..... Y N
    - k. Lung Disease? ..... Y N
    - l. Asthma? ..... Y N
    - m. Epilepsy? ..... Y N
    - n. Ulcers? ..... Y N
    - o. Hepatitis? ..... Y N
    - p. Arthritis? ..... Y N
    - q. Kidney Disease? ..... Y N
    - r. Glaucoma? ..... Y N
    - s. Bleeding disorder? ..... Y N
    - t. Psychologic disorders? ..... Y N
    - u. Liver Disease? ..... Y N
    - v. Suppressed immune system? ..... Y N
    - w. Sleep Apnea? ..... Y N

Please add any additional information you feel is important. _____

Do you have any other disease, conditions or problem not listed above that you think the Doctor should know about ..... Y N

_____ / _____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY **DR'S INITIALS**

ABINGTON ORAL AND MAXILLOFACIAL SURGERY, P.C.
DR. DAVID J. GUBA

Notice of Privacy Practices for Protected Health Information

I, _____, hereby acknowledge that I have 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 Date