Dr. Susana Porras Souchon
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www.elevatedoms.com

ELEVATED
ORAL SURGERY · DENTAL IMPLANTS · FACIAL AESTHETICS

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Pronoun: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Birthdate: _____ SSN# _____

Sex: ☐Male ☐Female Status: ☐Single ☐Married ☐Minor ☐Widowed ☐Divorced

Address: _____ City, St: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____ Physician: _____

Preferred Contact Method: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email ☐Text

Student: ☐No ☐Full Time ☐Part Time School Name: _____

Emergency Contact: _____ Phone: _____

Is this visit related to an accident? ☐Yes ☐No If yes, date of accident:_____

How did you learn about our practice? (provide name): _____

Responsible Party Information

First Name: _____ Middle Initial:_____ Last Name: _____

Relationship to Patient: _____ Birthdate: _____ SSN# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____

Preferred Contact Method: ☐Home Cell ☐Cell Phone ☐Work Phone ☐Email ☐Text

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Insurance Information

Primary Dental Insurance

Relationship to Patient: _____
Employer: _____
Insurance Co. Name: _____
Address: _____
City: _____ **St:** _____ **Zip:** _____
Phone# _____
Insured's Name: _____
Address: _____
City: _____ **St:** _____ **Zip:** _____
Phone: _____ **DOB:** _____
Insured's ID# _____
Group# (Plan, Local, or Policy) _____
SSN# _____

Secondary Dental Insurance

Relationship to Patient: _____
Employer: _____
Insurance Co. Name: _____
Address: _____
City: _____ **St:** _____ **Zip:** _____
Phone# _____
Insured's Name: _____
Address: _____
City: _____ **St:** _____ **Zip:** _____
Phone: _____ **DOB:** _____
Insured's ID# _____
Group# (Plan, Local, or Policy) _____
SSN# _____

General Health

Have you been a patient in a hospital in the past two years? If so, for what were you hospitalized? ❑No ❑Yes

_____

Are you now, or have you been, under the care of a physician (including a psychiatrists) during the past two years? If so, please describe below what you were treated for? ❑No ❑Yes

_____

Do you wear contact lens? ❑No ❑Yes

Are you now under a physician's care for any particular problem? ❑No ❑Yes

Have you ever had any illnesses, operations or hospitalizations? ❑No ❑Yes

If so, describe: _____

Please briefly state your reason for today's visit: _____

Height: _____ Weight: _____ Age: _____

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Health History

Have you ever had any of the following diseases or medical conditions or procedures?

☐Rheumatic Fever or Rheumatic Heart Disease
☐Congestive Heart Disease
☐Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpations, Heart Surgery, Pacemaker)
☐Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)
☐Seizures, Convulsions, Epilepsy, Fainting or Dizziness
☐Any disease, drug or transplant operation that has depressed your immune system
☐Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion
☐Radiation (X-ray) treatment for Cancer
☐Thyroid Disease (Goiter)
☐Artritis
☐Stomach Ulcers
☐Glaucoma
☐Cancer
☐Blood Disease
☐AIDS
☐Syphilis or venereal disease
☐Nervous disorders
☐Diabetes
☐Obstructive sleep apnea
☐Kidney or bladder trouble
☐Liver Disease (Jaundice, Hepatitis)

Medications & Allergies:

List medicines, or drugs, you have taken during the past year and for what conditions:

(include mg doses and frequency of use) (Please provide us with a medication list if available)

_____

_____

_____

Have you had any surgical procedures in the past? Describe below:

_____

If surgery was performed, name the surgeon: _____

Do you have any prosthetic implants placed anywhere in your body? (heart valve, hip, knee, etc.)

_____

Have you had any reactions to sulfites, hay fever or any other allergies? If so, please describe:

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Have you taken cortisone or other hormone medication? ❑Yes ❑No If so, please list:_____

When you cut yourself, or have a tooth extracted, do you bleed so much that you must see a doctor to have it stopped? ❑Yes ❑No

Have you ever had a reaction during, or following, dental treatment or oral surgery? ❑Yes ❑No

Are you allergic to or have you had an adverse reaction to Aspirin, sulfa, or penicillin? ❑Yes ❑No

Are you allergic to or have you had an adverse reaction to Codeine or other pain killers? ❑Yes ❑No

Do you faint easily? ❑Yes ❑No

Do you get short of breath easily? ❑Yes ❑No

Have you gained or lost more than fifteen pounds recently? ❑Yes ❑No

Do you smoke or chew tobacco? ❑Yes ❑No How much smoke or tobacco you use a day?_____

Do you have any sores or growths in your mouth? ❑Yes ❑No

Have you ever had any serious injuries to your face or jaws? ❑Yes ❑No Describe:_____

Have you had temporomandibular joint disorder or dysfunction? ("TMJ") ❑Yes ❑No

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ❑Yes ❑No _____

Are you currently taking oral Bisphosphonates? ❑Yes ❑No If yes, please list_____

Have you ever experienced an adverse reaction to anesthesia? ❑Yes ❑No

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For Women Only

Are you pregnant? ❑Yes ❑No