

PACIFIC CREST

ORAL SURGERY & DENTAL IMPLANTS

Matthew T. Dailey, DDS, MD | Jeffrey Garcia, DDS
683 California Boulevard | San Luis Obispo, CA 93401
Telephone 805.541.6725
Diplomate of the American Board of Oral & Maxillofacial Surgery

Today's Date _____

PATIENT INFORMATION:

First Name _____ MI _____ Last Name _____

Sex assigned at birth: ❑ Male ❑ Female Gender identity: ❑ Man ❑ Woman ❑ Non-binary

Birth Date _____ Age _____ Social Security # _____

Street _____ Apt _____

City _____ State _____ Zip _____ Country _____

Email _____

Mobile (_____) _____ Ok to text? ❑Yes ❑No Phone (_____) _____

Dentist _____ Phone _____

Orthodontist _____ Phone _____

Medical Doctor 1 _____ Phone _____

Employer _____ Business Phone (_____) _____

Emergency Contact _____ Phone (_____) _____ Relation _____

Referred By : _____

Preferred Pharmacy: _____

PERSON FINANCIALLY RESPONSIBLE FOR YOUR ACCOUNT:

Dental Insurance Company: _____

❑ Self (if self, skip this section ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ Social Security _____

Birth Date _____ Age _____ Phone (_____) _____

Street _____ Apt _____

City _____ State _____ Zip _____

Email _____

Employer _____ Business Phone (_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ Relation _____

Birth Date _____ Social Security _____

Street _____ Apt _____

City _____ State _____ Zip _____ Country _____

Email _____ Phone (_____) _____

Employer _____ Business Phone (_____) _____

MEDICAL HISTORY

The reason you are seeking treatment?

_____

Date symptoms started _____ Have your symptoms increased with time? ..... ❑ Y ❑ N

Height _____ Weight _____ Are you in good health? ..... ❑ Y ❑ N

Hospitalizations/Surgeries	Date(s)	Reason	Complications: nausea, bleeding, anesthetic, prolonged healing, allergies

Have you or any family member had any unusual or serious reactions to general or local anesthetic? ..... ❑ Y ❑ N

Is there a family history of: ❑ cancer ❑ diabetes ❑ heart disease ❑ bleeding ❑ arthritis ... ❑ Y ❑ N

Have you had an artificial joint replacement? (knee, hip, shoulder) ..... ❑ Y ❑ N

Have you had a heart valve procedure or replacement? ..... ❑ Y ❑ N

Do you use: ❑ vape ❑ pipe ❑ cigar ❑ chewing tobacco ❑ cigarettes (packs per day) _____ How long? _____ ❑ Y ❑ N

Do you use any recreational drugs? ❑ marijuana ❑ other _____ ❑ Y ❑ N

Do you drink alcoholic beverages? If so, number of drinks per day _____ .....❑ Y ❑ N

History of medication, drug, or alcohol abuse? ..... ❑ Y ❑ N

FEMALES ONLY

Is there a possibility that you are pregnant? If so, month(s) _____ due date _____ ❑ Y ❑ N

Are you nursing? ❑ Y ❑ N

Has your menstrual cycle been irregular in the past? ❑ Y ❑ N

Do you currently have an irregular menstrual cycle? ❑ Y ❑ N

Do you currently have a regular menstrual cycle? ❑ Y ❑ N

At what age was your first menstrual cycle? _____

If menopausal, at what age did this start? _____

Are you currently taking or have you ever used birth control? ❑ Y ❑ N

Current birth control type: ❑ 'Pill' ❑ IUD ❑ Injection Name _____ How long? _____

Previous birth control type: ❑ 'Pill' ❑ IUD ❑ Injection Name _____ How long? _____

NOTE: Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control while on any antibiotics.

MEDICATIONS

Are you taking Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, garlic, fish oil, etc.)? ❑ Y ❑ N

Are you taking or have ever taken bone density medications and/or bisphosphonates (Actonel, Boniva, Fosamax,

Intravenous Aredia or Zometa)? ❑ Y ❑ N

Are you taking or have ever taken diet pills?

Name_____ How long? _____ ❑ Y ❑ N

Please list ALL medications, herbal supplements, or homeopathic remedies you are currently taking:		
Medications	**Dosage**	**Frequency**

ALLERGIES

ALLERGIES OR HAD REACTIONS	YES	NO
Local anesthetics		
Penicillin's		
Cephalosporin's		
Tetracycline		
Other antibiotics		
Sulfa drugs		
Aspirin		
NSAIDS (ibuprofen, naproxen, etc.)		

ALLERGIES OR HAD REACTIONS	YES	NO
Narcotics (codeine, morphine, Vicodin, Percocet, etc.)		
Latex		
Soy		
Eggs		
Do you have any other known allergies?		
List any other allergies:		

CONDITIONS: Circle one of the below listed if you currently have or had any of the following

ADHD
Alzheimer's/Dementia
Anemia
Anxiety Treated / Untreated
Arthritis
Asthma
Astigmatism
Bell's Palsy
Blood Disorders
Blood Transfusions
Body Dysmorphic Disorder
Bronchitis
Bruise or Bleed Easily
Cancer
Cardiac Pacemaker
Chest Pain/ Angina
Cold Sores/ Fever Blisters
Connective Tissue Disorder
Fibromyalgia
Gall Bladder Issues
Gastrointestinal Issues (Reflux, GERD, IBS)
Glaucoma
Heart Attack(s)
Heart Murmur
Heart Valve Problems
Hepatitis (A, B, OR C)
High Blood Pressure
High Cholesterol
HIV/AIDS
Hyper/Hypo Glycemia
Hypermobility/Hyper flexibility
Insomnia
Irregular Heartbeat
Jaundice
Joint disease
Night Sweats
Obsessive-compulsive disorder
Osteonecrosis
Osteopenia / Osteoporosis
Parkinson's
Pneumonia
Premature birth
Previous Heart Surgery
Rheumatic Fever
Scarlet Fever
Seizure disorder
Sexually transmitted diseases
Sleep apnea
Stroke
Swollen ankles Tuberculosis
Tumors or growths

Cough - chronic
Depression Treated / Untreated
Diabetes Type 1 / Type 2
Eating Disorder Bulimia / Anorexia
Fainting
Fatigue - chronic
Kidney Disease
Liver Disease
Low Blood Pressure
Lung Disease
Lyme Disease
Menopause
Ulcer
Unexplained weight loss/gain
Vertigo
Vision correction (surgery, glasses, or contact lenses)
Other_____
Thyroid disease

FUNCTIONAL HISTORY

TMJ HISTORY

Do you hear clicking sounds in front of your ear(s)? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you hear popping sounds in front of your ear(s)? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you hear grinding sounds in front of your ear(s)? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have pain in front of your ear(s)? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Does your jaw deviate to one side when you open? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have decreased jaw opening? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Does your jaw get stuck open? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Does your jaw get stuck closed? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
When are your symptoms worse? ..... ❑ AM ❑ PM ❑ No difference _____

MUSCLE HISTORY

Do you have pain in the cheek area? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have pain in the temples? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have pain behind your jaw?..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have neck aches or backaches? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you have headaches? ..... ❑ Y ❑ N ❑ R ❑ L ❑ Past ❑ Present _____
Do you get migraines? ..... ❑ Y ❑ N _____
When are your symptoms worse? ..... ❑ AM ❑ PM ❑ No difference _____
Do you have to posture your jaw to be comfortable? ..... ❑ Y ❑ N _____
Do you clench your teeth during the day? ..... ❑ Y ❑ N _____
Do you grind your teeth in your sleep? ..... ❑ Y ❑ N _____
Are you in an emotional or stressful period of your life? ..... ❑ Y ❑ N _____

I certify that I have read and I understand the questions throughout this questionnaire. I acknowledge my questions, if any, about the inquiries set forth throughout this questionnaire have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of these forms.

X _____ X _____

Signature of patient *(Patient or Guardian if Minor)* **Date**