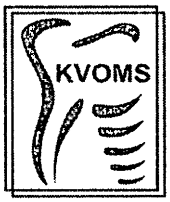

Kankakee Valley Oral Maxillofacial Surgery

WELCOME TO OUR PRACTICE

Patient Information:

First Name_____ _____M.I._____Last Name_____

Birth Date_____Age_____ Sex (M / F) Social Security#_____

Address_____Apt_____City_____State_____Zip_____

Phone #(_____)_____ Alt. Phone#(_____)_____

Email_____

Who Will Be Financially Responsible For Your Account:

Self_____ Spouse_____ Parent_____ Other_____

First Name_____M.I._____Last Name_____

Birth Date_____Social Security#_____Phone #(_____)_____

Address_____Apt_____City_____State_____Zip_____

Insurance Information

Dental Insurance Company_____Phone #(_____)_____

Address_____City_____State_____Zip_____

I.D.#_____Group#_____

Policy Holder Name_____Relationship to Patient_____

Birth Date_____Social Security#_____Phone#(_____)_____

Employer_____

Medical Insurance Company_____Phone #(_____)_____

Address_____City_____State_____Zip_____

I.D. #_____Group#_____

Policy Holder Name_____Relationship to Patient_____

Birth Date_____Social Security #_____Phone#(_____)_____

Employer_____

Kankakee Valley
Oral Maxillofacial Surgery
31 Briarcliff Professional Center
Bourbonnais, IL 60914-1775
Christopher Powell D.D S.
kvalleyoms.com

Covid-19 Questionnaire

1.) Have you been diagnosed with COVID-19? ☐ YES ☐ NO
If YES, do you have persistent or long-haul symptoms? ☐ YES ☐ NO
If YES, please describe:_____
_____

2.) Have you been vaccinated? ☐ YES ☐ NO
If YES, date of last vaccine:_____

3.) Have you tested positive for COVID-19 in the past 14 days? ☐ YES ☐ NO
If YES, type of test: __Blood __Nasal Swab __Saliva

4.) Have you been in contact with anyone in the past 14 days who tested positive for COVID-19? ☐ YES ☐ NO

5.) Have you experienced any loss of taste and/or smell? ☐ YES ☐ NO

6.) Have you traveled in the last 14 days? ☐ YES ☐ NO
If YES, where and what mode of transportation?
_____

7.) Are you considered immunocompromised? ☐ YES ☐ NO

8.) Do you have any other COVID-19 concerns? ☐ YES ☐ NO
If yes, please elaborate:_____
_____

Patient Name:_____

Signature:_____

Date:_____

HEALTH HISTORY

NAME: _____ AGE: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ SEX: ____M___/____F_____

PHYSICIAN'S NAME: _____

*Please list specifics to any YES answers on the back of this form

GENERAL	YES	NO
1. Are you in good health?	Y	N
2. Are there any changes to your health in the last year?	Y	N
3. Have you had any operations requiring general anesthetic?	Y	N
a. Please list on the back with approximate dates		
4. Are you on any medications?	Y	N
a. Please list on the back		
5. Have you ever had an allergic reaction?	Y	N
6. Do you have any allergies to medications?	Y	N
a. Please list on the back		
7. Are you allergic to latex?	Y	N
8. Have you been told to take an antibiotic before dental treatments?	Y	N
9. Do you take a blood thinner?	Y	N
10. Do you use alcohol or recreational drugs regularly?	Y	N
11. Are you pregnant?	Y	N
12. Do you use contraceptive therapy?	Y	N
13. Have you ever fainted?	Y	N
14. Do you smoke or vape?	Y	N
15. Do you chew tobacco?	Y	N
16. Do you wear contacts?	Y	N

SPECIFIC	YES	NO
1. Have you had a heart valve replacement?	Y	N
2. Do you have any heart problems?	Y	N
a. Please list on the back		
3. Do you have any breathing issues?	Y	N
a. Please list on the back		
4. Do you have kidney disease?	Y	N
5. Are you on dialysis?	Y	N
6. Are you diabetic?	Y	N
7. Have you had cancer, chemotherapy, and/or radiation?	Y	N
8. Have you had a stroke?	Y	N
9. Have you had a seizure?	Y	N
10. Do you have liver disease?	Y	N
11. Do you have thyroid disease?	Y	N
12. Do you have osteoporosis or osteopenia?	Y	N
13. Do you have an autoimmune disease?	Y	N
14. Do you have any TMJ issues?	Y	N
15. Have you ever been treated for any mental health issues?	Y	N

Surgeries:

Medications:

Allergies:

Other:

Heart Problems:
Please check all that apply:

Heart Attack_____ Chest Pain_____ Arrythmias_____ High Blood Pressure_____
Low Blood Pressure_____ Other_____

Breathing Problems:
Please check all that apply:

Sleep Apnea_____ Snoring_____ COPD_____ Asthma_____ Other_____

Do you have any questions you would like to ask the doctor in confidence or privately?
Yes_____ No_____

Date	Signature of Person Completing Health History	Relationship	Doctor's Signature

Updates to Health History

New Surgeries:

New or Discontinued Medications:

New Allergies:

Other:

Date	Signature of Person Completing Health History	Relationship	Doctor's Signature