POMS
Parkview Oral and Maxillofacial Surgery

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Initial Patient Form:

OHIP#:

Reason for Visit:

Name:
FIRST LAST

Age: DOB: / / Sex: M F
MM DD YYYY

Address:

City: Postal Code:

Home Phone: Other:

Referring Dentist: Family Dentist:

Family Physician:

In case of Emergency please notify: Phone:

Do you have dental insurance: ☐ No ☐ Yes (If yes please provide the following information)

Primary Dental Insurance:	**Secondary Dental Insurance:**
Insurance Company	Insurance Company
Name of Policy Holder	Name of Policy Holder
Date of Birth	Date of Birth
Relation to Patient	Relation to Patient
Group Number	Group Number
Patient ID Number	Patient ID Number

IMPORTANT: On day of surgery with General Anaesthetic or Intravenous Sedation, you must be accompanied by an adult and they must remain in the office for the COMPLETE VISIT.

FEES: OHIP does not cover office procedures: DENTAL INSURANCE MAY NOT COVER THE TOTAL FEE. Full payment is required the day services are rendered. Please note that the financial obligation is between you and this office.

Are you in good health: ☐ Yes ☐ No

Are you under the care of a physician for any medical condition within the last 2 yrs? ☐ Yes ☐ No

If yes, please explain: ____________________

Are you pregnant (if applicable): ☐ Yes ☐ No

Have you ever been hospitalized? Explain: ____________________ ☐ Yes ☐ No

Have you recently, or are you presently, taking any PRESCRIPTION or NONPRESCRIPTION DRUGS:

1.	2.	3.
4.	5.	6.
7.	8.	9.

Are you allergic to any medications, foods or latex? ☐ Yes ☐ No

If yes, please list: ____________________

Do you have an artificial joint of any kind? ☐ Yes ☐ No

If yes, please explain: ____________________

Are you HIV Positive or have AIDS? Explain ____________________ ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No

If yes, please list: ____________________

Do you smoke or use other forms of tobacco? ☐ Yes ☐ No

If yes, please list: ____________________

Other medical conditions? Explain: ____________________ ☐ Yes ☐ No

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:

Condition			Condition			Condition		
Anemia	☐ Yes	☐ No	Intestinal Problems	☐ Yes	☐ No	Latex Allergy	☐ Yes	☐ No
Heart Attack or Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Sexually transmitted Dis.	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	High/Low Blood Press	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No	Radiation	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No	Hodgkin's Disease	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Heart Rhythm Disorder	☐ Yes	☐ No	Circulation Problems	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Psychiatric treatment	☐ Yes	☐ No	Hyper/Hypo Glycemia	☐ Yes	☐ No	Glandular Disorders	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Congenital Heart Dis	☐ Yes	☐ No	TMJ Problems	☐ Yes	☐ No
Rheumatic/Scarlet Fever	☐ Yes	☐ No	Hepatitis A,B,C	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Peptic Ulcers	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Cortisone/Steroid Use	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Head and Neck Injury	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Drug/Alcohol Addiction	☐ Yes	☐ No	Malignant Hyperthermia.	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No