JOSEPH J. PELKOFSKI, D.M.D.
ORAL AND MAXILLOFACIAL SURGERY

Medical History: Answers to the following are for our records only and will be considered confidential.

NAME: ____________________ BIRTHDATE: __________ AGE: ______

PLEASE ANSWER ALL QUESTIONS

1. Are you being treated by a doctor now? No ______ Yes ______
1A. If yes, list condition being treated and doctor following you: ____________________

2. Are you taking any medications? (prescription, over-the-counter, or herbal supplements) No ______ Yes ______
2A. If yes, list all medications, milligrams, and how prescribed: ____________________

3. Have you had any surgery, outpatient treatment, or been hospitalized? No ______ Yes ______
3A. If yes, list all treatments, place of treatment and attending physician: ____________________

4. Please indicate if you have or have ever experienced any of the following conditions?

Rheumatic fever or rheumatic heart disease ______
Heart attack or heart trouble ______
Heart Surgery ______
Hip or other joint replacement ______
Diabetes ______
Stroke ______
High or Low Blood Pressure ______
Thyroid trouble ______
Kidney trouble ______
Liver trouble (Hepatitis) ______
Stomach ulcers ______
Venereal disease ______
Chemotherapy ______
Radiation therapy ______
TMJ or jaw joint trouble ______

Autoimmune Disease ______
Arthritis ______
Inflammatory Rheumatism (painful swollen joints) ______
Hormone or Steroid usage ______
Asthma/shortness of breath ______
Allergies ______
Hay fever/sinus ______
Epilepsy/convulsions/seizures ______
Latex allergy ______
Excessive bleeding ______
Anemia/blood disorder ______
Transfusion ______
Tire easily ______
Facial bone injuries ______
Fainting/passing out spells ______

Other:

Height: ______ **Weight:** ______

5. Have you ever had an unusual reaction to any of the following drugs? No ______ Yes ______
5A. If yes, list reaction next to medication:

Aspirin ______
Advil/Ibuprofen ______
Tylenol ______
Penicillin ______
Narcotics (Codeine, Percocet, etc.) ______

Anesthetic drugs ______
Iodine ______
Sulfonamides (Sulfa) ______
Any other medication ______

Name ______________________________ Birthdate ________________________

6. Do you ever have hives or a skin rash? No ________ Yes ________

7. Do you use tobacco products? (smoke/dip/chew) ____________ How much? ____________

Do you drink alcohol? ____________ How much? ____________

Do you use recreational drugs? ____________ How much? ____________

8. Do you wear contact lenses? No ________ Yes ________

9. Have you ever experienced any unusual reaction to a local anesthetic (Novocaine or Lidocaine) or General anesthetic? No ________ Yes ________

9A. Has anyone in your immediate family ever experienced an unusual reaction to anesthetic drugs? (local or general anesthesia) No ________ Yes ________

If yes, please list type of reaction: ____

____

10. Do you or your family have any other medical conditions, syndromes, diagnoses, etc., that should be brought to our attention? No ________ Yes ________

If yes, please explain: ____

____

____

____

For female patients:

Date of last menstrual period: ____________________

Are you breastfeeding? ____________________

Are you pregnant? ________ Month? ____________

The above statements are correct, and I consent to examination and treatment.

Date: __________ Signature: ____ Relationship to patient: __________

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Patient Information:

Name: ______________________________ Age: __________

☐ married ☐ single ☐ widowed ☐ divorced ☐ separated Birth Date: __________

Street Address: ______________________________

____

Home Telephone: (____) ______________ Cellular Phone: (____) ______________

Mailing Address (if different from street address): ______________________________

____

Patient's School or Employer: ______________________________

Business Address: ______________________________

Business Telephone: (____) ______________ Occupation: ______________

Social Security Number: ______________________________

Spouse, Parental, or Guardian Information:

Name of Spouse, Parent, or Guardian: ______________________________

Employer: ______________________________

Business Address: ______________________________

Business Telephone: (____) ______________ Cellular Phone: (____) ______________

Occupation: ______________ Relationship to patient: ______________

Social Security Number: ______________ Birth Date: ______________

Spouse, Parental, or Guardian Information:

Name of Spouse, Parent, or Guardian: ______________________________

Employer: ______________________________

Business Address: ______________________________

Business Telephone: (____) ______________ Cellular Phone: (____) ______________

Occupation: ______________ Relationship to patient: ______________

Social Security Number: ______________ Birth Date: ______________

Dentist: ______________________ **Referred By:** ______________

Doctor: ______________________

List Family Members Seen in this Office: ______________________________

Insurance Company and Policy Numbers: *(please provide ID cards to receptionist for photocopying)*

Dental: ______________________________

Medical: ______________________________

- I certify that the above information is correct. In cases of minors, dependent patients, divorced parents, etc., the guardian or parent accompanying the patient will be deemed responsible for payment.

______________________________(Signature & Date)

- I authorize my insurance carrier to reimburse Dr. Pelkofski for services rendered.

______________________________(Signature & Date)

JOSEPH J. PELKOFSKI, D.M.D.

ORAL AND MAXILLOFACIAL SURGERY

16 ROYAL STREET, S.E.

LEESBURG, VIRGINIA 20175

TELEPHONE (703) 777-5200

AUTHORIZATION FOR JOSEPH J. PELKOFSKI, DMD TO RELEASE HEALTH CARE INFORMATION

Patient's Name:_______________________________________ Previous name:______________

SSN:____ Date of Birth:______________

I authorize Dr. Pelkofski and practice to release health care information of the patient named above to:
-Insurance carriers; -Health Care Providers; -Billing/Collection Agencies; - Voice Mail Messaging;
___ Other (please specify):

This authorization applies to all care performed by Dr. Pelkofski as well as all health care information unless otherwise specified.
___ Other (please specify):

This authorization expires upon completion of my care and financial settlement unless otherwise specified by me.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

-Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

-Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

____

Signature of patient or patient's authorized representative Date signed

____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

NOTICE OF PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT

I, ____, hereby acknowledge that
(print patient name)

I have read and reviewed a copy of Dr. Joseph Pelkofski's Notice of Patient Privacy Practices. I have been given the opportunity to ask any questions that I may have regarding this Notice. I understand that I may receive a copy of this Notice for my own personal records upon request.

____

Signature of patient or patient's authorized representative Date signed