James G. Loeser, D.D.S., M.D., PC
Surgery of the Mouth, Jaws, and Face

All personal information is held in the strictest confidence.
Use the TAB key to move between fields.

Patient Information:

Date _____

First Name: _____ MI: __ Last Name: _____ Title: _____

Nickname _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: ___ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Student: _____ School: _____

Have you been a patient of our practice before: _____

Insurance Information (if different from above)**:**

Who is responsible for this account: _____

First Name: _____ MI: __ Last Name: _____ Title: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Birth Date: _____ Age: ___ Cell Phone: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse Name: _____ Occupation: _____

Referral Information:

Who referred you to our office: _____

General Dentist: _____ Office Phone: _____

Orthodontist: _____ Office Phone: _____

Physician: _____ Office Phone: _____

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Medical History:

Do you have or have you had any of the following?

Heart attack	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No	Autoimmune disorders	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Immune system deficiency	☐ Yes	☐ No
COPD / emphysema	☐ Yes	☐ No	Drug / alcohol addiction	☐ Yes	☐ No
Kidnery failure / dialysis	☐ Yes	☐ No	Anxiety / psychiatric care	☐ Yes	☐ No
Hepatitis / liver disease	☐ Yes	☐ No	Painful / clicking jaw joints	☐ Yes	☐ No
Stroke / mini stroke / CVA	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Blood clots / DVT / PE	☐ Yes	☐ No			
Bleeding disorders	☐ Yes	☐ No	Cancer / malignancy	☐ Yes	☐ No
Seizures / epilepsy	☐ Yes	☐ No			
Asthma / hay fever	☐ Yes	☐ No	Site: _____		
Sinus infections	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No

☐ Yes ☐ No Have you ever taken drugs to treat osteoporosis (Boniva, Fosamax, Actonel, Zometa, Aredia)?

☐ Yes ☐ No Do you take blood thinners (Coumadin, Warfarin, Plavix, Aspirin, Arixtra)?

☐ Yes ☐ No Do you have artificial joints / hips / knees?

☐ Yes ☐ No Do you smoke or have you ever smoked? Quit? ☐ Yes ☐ No Year: _____

☐ Yes ☐ No Could you be pregnant?

☐ Yes ☐ No Have you or any member of your family had a complication from a local or general anesthetic?

Illnesses or conditions not listed above:

Please list all medicines taken now or in the past year: (attach a sheet for long lists)

Please list all previous surgeries:

Please list any allergies (e.g. medicines, latex):

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

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Primary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Insured SS#:
Metlife Only _____

Primary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Secondary Dental Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Insured SS#:
Metlife Only _____

Secondary Medical Insurance

Insurance Carrier: _____

Name of Insured: _____

Group Name: _____

Group #: _____

ID #: _____

Policy Plan: _____

Patients under 18 must have a parent/legal guardian present.

Please print this form, sign & date , and bring with you to your appointment.

Print Form