Michael B. Lee, D.D.S.
Diplomate American Board of Oral & Maxillofacial Surgery
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Cincinnati Center *for* CORRECTIVE JAW SURGERY
Surgical Expertise | Technology Driven
Committed to Patient Recovery

Consultation Date:	Patient ID:

PATIENT INFORMATION

Name:			Marital Status: S M D W
DOB: / /	Age:	Gender: [ ] M [ ] F	Social Security #: - -
Preferred Method of Contact: [ ] Cell Phone [ ] Email [ ] Text Message [ ] Home Phone [ ] Work Phone			
Home Address:			
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	
Email Address: **(By providing your email address, you are aware that there is some level of risk that third parties might be able to read unecrypted emails and you agree that the practice may communicate with you electronically at the email address provided. You are responsible for providing the practice with any updates to your email address and may withdraw your consent to electronic communications by calling 513-232-8989.)**			
Occupation:	Employer:		

IF UNDER 21 YEARS OF AGE:

Mother's Name:	Mother's Address:
Mother's Phone:	Mother's Employer:
Father's Name:	Father's Address:
Father's Phone:	Father's Employer:

Dentist: City/State:	Phone: ( ) -
Orthodontist: City/State:	Phone: ( ) -
Primary Care Physician: City/State:	Phone: ( ) -
Pharmacy: City/State:	Phone: ( ) -
Specialty Care Physician (ie. cardiologist, internist)	Phone: ( ) -
Who may we thank for referring you to our office?	

FAMILY INFORMATION

Names of family members treated by Dr. Lee:	
Spouse Name:	Spouse DOB: / /

HEALTH HISTORY

CONDITION:	YES	NO	If yes, provide the additional information, if you can:
AIDS			
Alzheimer’s			
Arthritis			Is your jaw joint involved?
Artificial Heart Valve			When was it placed? What type is it?
Artificial Joint			Which joint? When was it placed?
Asthma			Last visit to the hospital for treatment:
Blood Thinners			How often? INR Level?
Cancer/ Leukemia			Where was your cancer located? What year were you diagnosed?
Chemotherapy			Last chemotherapy treatment:
Chest Pain			
Chronic Bronchitis			
Diabetes			A1C level: Do you check your sugar levels?
Drug or Alcohol Abuse			Currently in treatment?
Do you smoke marijuana?			How often?
Emphysema			Last ER visit for this?
Epilepsy or Seizures			
Glaucoma			

HEART HISTORY

Heart Attack			
Heart Failure			
Mitral Valve Prolapse			
Do you have a Pacemaker or Defibrillator?			
Heart Surgery			Were stints placed? How long ago?
Can you climb a flight of stairs?			
Do you experience shortness of breath?			How often?

Describe your activity level capability. (ie. play golf, garden, walk, jog, etc.)

Hemophilia			
Hepatitis			What type?
High Blood Pressure			
Kidney Trouble			
Liver Disease			
Osteoporosis			How long have you been on medication for it?
Pain in Jaw Joint			Right or Left or both?
Have you had physical therapy?			
Do you have a bite splint?			
Psychiatric Treatment			
Rheumatic Fever			
Sleep Apnea/ Sleep Disordered Breathing			
Have you had a sleep study?			(Check one) Home Test _____ Sleep Center _____
Do you use a C-PAP?			
Sleep Doctor/Name of Sleep Center			
Stroke			
Thyroid Disease			
Tuberculosis (TB)			
Ulcers/ Gastric Reflux			
Do you have pain or discomfort at this time?			If yes, please specify:
Are you nervous about having surgery?			
Have you been hospitalized in the past year?			For what condition(s)?
Have you ever had general anesthetic?			If so, did you experience any complications?
Have you had excessive bleeding in the past?			
Do you have a history of motion sickness?			
Do you smoke?			How much?
Females Only? Are you pregnant?			

Please list all current prescription medications:	**Indicate meds taken morning/ afternoon/ evening:**
1.	
2.	
3.	
4.	
5.	
6.	

7.	
8.	
9.	
10.	
Please list all over-the-counter medications:	**Indicate meds taken morning/afternoon/evening:**
1.	
2.	
3.	
4.	
5.	
6.	

Please list any allergies to medications:
Allergic to Latex? [ ] **Y** [ ] **N**
Do you have any disease, condition or problem not specifically listed which you think Dr. Lee should know about?

To the best of my knowledge, all of the preceding answers are true and correct. I speak, write and understand English.

Signature: ____ Date: ___________________

Parent or Guardian: _____________________________________ Date: ___________________

PRIVACY & COMMUNICATION PREFERENCES

Do you give our office permission to discuss your medical information with someone other than yourself?

[ ] **Y** [ ] **N**

If yes, please provide name, telephone number and relationship of said individual(s):

____

____

May we leave personal medical information on your answering machine or cell phone? [ ] **Y** [ ] **N**

May we email encrypted personal medical information to you using the email address you provided? [ ] **Y** [ ] **N**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received and read or been offered a copy of your Notice of Privacy Practices containing detailed information related to my personal health information. I understand that this office has the right to modify its Notice of Privacy Practices from time to time and I may request a copy of same at any time.

Signature: ____ Date: ______________________

AUTHORIZATION FOR DISCLOSURE

From time to time, the Cincinnati Center for Corrective Jaw Surgery may want to share patient information for purposes of training, education seminars, writing articles, demonstrating pre-surgical and post-surgical outcomes, and gather statistics. Please indicate by checking the appropriate box whether or not you authorize the Cincinnati Center for Corrective Jaw Surgery to use your patient information as specifically outlined above.

[ ] I DO authorize Cincinnati Center for Corrective Jaw Surgery to share my patient information.

[ ] I DO NOT authorize Cincinnati Center for Corrective Jaw Surgery to share my patient information.

Signature: ____ Date: ______________________