

Welcome to our Practice

PATIENT INFORMATION:

Registration Type: Patient

First Name: _____ Middle Initial: ____ Last Name: _____ Date: ____/____/____
Birthdate: ____/____/____ Soc. Sec. #: ____-____-____ Email: _____ Sex: _____
Street 1: _____ Street 2: _____
Apartment #: _____ City: _____ State: _____ ZIP: _____
Home Tel: _____ Mobile Tel: _____ Referred By: _____
Have you ever been a patient of our practice? Y / N Has a family member ever been a patient of our practice? Y / N
Referring Dentist: _____ Orthodontist: _____ Medical Dr.: _____
Preferred Pharmacy: _____ Tel: _____ Payment Type: Check / Credit / Cash
Nearest relative not living with you: _____ Tel: _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Relationship: *(Please circle one. If self, skip this section)* Self / Spouse / Father / Mother / Other: _____
First Name: _____ Last Name: _____
Birthdate: ____/____/____ Soc. Sec. #: ____-____-____ Email: _____
Street 1: _____ Street 2: _____
Apartment #: _____ City: _____ State: _____ ZIP: _____
Home Tel: _____ Mobile Tel: _____
Employer/Business Name: _____ Business Phone: _____

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE):

First Name: _____ Last Name: _____ Phone: _____
Birthdate: ____/____/____ Soc. Sec. #: ____-____-____ Email: _____
Street 1: _____ Street 2: _____
Apartment #: _____ City: _____ State: _____ ZIP: _____

INSURANCE INFORMATION:

Employment Type: *(Please circle one)* Full Time / Part Time / Retired / Not Employed
Marital Status: *(Please circle one)* Single / Married / Divorced / Widow / Legally Separated
Student Status: *(Please circle one)* Full Time / Part Time / Not a student School Name: _____

PRIMARY DENTAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/__ Soc. Sec. #: ____-____-____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/__ Soc. Sec. #: ____-____-____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY DENTAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/__ Soc. Sec. #: ____-____-____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

PRIMARY MEDICAL INSURANCE COMPANY:

Employer: _____

Tel.: _____ Plan: _____

Ins. Co. Name: _____ ID #: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Ins. Tel.: _____

Group Name: _____ Group #: _____

Insured Party: _____

Relation: Self / Spouse / Father / Mother

Birthdate: __/__/__ Soc. Sec. #: ____-____-____

Sex: M / F Tel.: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

HEALTH HISTORY:

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason For Today's Office Visit _____

Height _____ **Weight** _____ **Are you in good health?** Y / N

Have there been any changes in your general health in the past year? Y / N

If so, describe _____

Are you under the care of a physician? Y / N

Date of last visit _____ **If so, what are you being treated for?** _____

Have you had any illness, operation, or been hospitalized in the past five years?..... Y / N

If so, describe _____

Do you have a prosthetic joint/implant?..... Y / N

If so, describe _____

Have you had a heart valve replacement or vascular graft?..... Y / N

If so, describe _____

Have you ever had general anesthesia?..... Y / N

If so, describe _____

Have you, or a family member, had any unusual or serious reactions to general anesthesia?..... Y / N

If so, describe _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....Y / N

If so, describe _____

Continued on next page.

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Rheumatic fever?..... Y / N
Damaged heart valves/mitral valve prolapse? Y / N
Heart murmur? Y / N
High blood pressure?..... Y / N
Low blood pressure? Y / N
Chest pain / angina?..... Y / N
Heart attack(s)?..... Y / N
Irregular heart beat? Y / N
Cardiac pacemaker? Y / N
Heart surgery? Y / N
Pneumonia, bronchitis or chronic cough? Y / N
Asthma?..... Y / N
Hay fever / sinus problems?..... Y / N
Snoring?..... Y / N
Sleep apnea / CPAP? Y / N
Difficulty breathing / other lung trouble? Y / N
Tuberculosis?..... Y / N
Emphysema?..... Y / N
Do you smoke or vape?..... Y / N
If so, how much per day? _____
Do you use marijuana?..... Y / N
Do you use chewing tobacco? Y / N
Blood transfusion?..... Y / N
Blood disorder such as anemia?..... Y / N
Bruise easily? Y / N
Bleeding tendency / abnormal bleed? Y / N
Hepatitis, jaundice, or liver disease? Y / N
Infectious mononucleosis? Y / N
Gallbladder trouble?..... Y / N
HIV / AIDS? Y / N

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

Fainting spells?Y / N
Convulsions / epilepsy?Y / N
Stroke?Y / N
Thyroid trouble?.....Y / N
Diabetes?.....Y / N
Low blood sugar?.....Y / N
Kidney trouble?Y / N
High cholesterol?Y / N
Are you on dialysis?Y / N
Swollen ankles, arthritis or joint disease?Y / N
Osteoporosis / osteopenia?Y / N
Osteonecrosis?.....Y / N
Stomach ulcers / acid reflux?.....Y / N
Contagious diseases?.....Y / N
Sexually transmitted diseases?Y / N
Problems with immune system?Y / N
Delay in healing?.....Y / N
A tumor or growth?.....Y / N
Cancer, radiation therapy or chemotherapy?.....Y / N
Chronic fatigue / night sweats?Y / N
Are you on a diet?.....Y / N
A history of alcohol abuse?Y / N
A history of marijuana or other drug use?Y / N
Contact lenses?Y / N
Eye disease / glaucoma?Y / N
Mental health problems / anxiety / depression?.....Y / N
Removable dental appliance?Y / N
Pain or clicking of jaws when eating?.....Y / N

WOMEN ONLY:

Is there a possibility of pregnancy? Y / N
Are you Nursing? Y / N
Date of your last period? _____

Expected delivery date? _____
Are you taking birth control pills? Y / N

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.

Continued on next page.

ARE YOU ALLERGIC OR HAD A REACTION TO:

Local anesthetic (numbing medication) Y / N
Penicillin Y / N
Other antibiotics Y / N
Sulfa Drugs Y / N
Sodium pentothal, Valium, or other tranquilizers .. Y / N
Aspirin Y / N
Amoxicillin Y / N
Codeine or other narcotics Y / N
Latex Y / N
Soy Y / N
Eggs/Yolk Y / N
Sulfites Y / N
Do you have any known Allergies Y / N

Please list any allergies other than drug allergies:

Please list any other medications or antibiotics you are allergic to.

Family history of cancer? Y / N
Family history of diabetes? Y / N
Family history of heart disease? Y / N
Family history of anesthesia problems? Y / N
Family history of autism? Y / N
Is there any condition concerning your health that the doctor should be told about? Y / N

Describe:

Do you wish to speak to the doctor privately about anything? Y / N
Describe

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? Y / N

ARE YOU NOW TAKING:

Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish oil)? Y / N

Have you ever taken diet pills? Y / N

Any natural product, herbal supplement or homeopathic remedy? Y / N

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years ? Y / N

Have you ever taken tranquilizers, sleeping pills, anti-depressants and/or narcotics on a regular basis Y / N
If yes, please list:

If you are under the care of a physician for pain management, or recovering from drug addiction please circle the medication you are currently taking:

Methadone / Suboxone / Oxycodone / Fentanyl / Other
If Other, description:

Doctor name:

Are you taking any kind of medication, drug, pills? Y / N

(If yes, list below)

Medication	Dosage	Frequency

Who is driving you home? _____

Mobile Number _____

Pick-up status _____

Conclusion

Emergency Contact

First Name: _____ Last Name: _____ Home Tel: _____

Cell: _____ Relation: _____

Accident

Is this related to an accident? Y / N If yes, what type? _____ Date of Injury _____

Insurance company handling this claim: _____ Insurance Claim Number _____

Name of Attorney/Adjustor: _____ Attorney/Adjustor Phone: _____

Verification

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature

Date

Release of Information

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature

Date

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature

Date

Authorization for Service

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

Signature

Date

Notice of Privacy Practices

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature

Date