

PATIENT REGISTRATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name_		_M.I Last Name	e	
Sex: ☐ Male ☐ Female Birth Date	Age Soc.	Sec. #	E-mail	
Street_	Apt.	City	State	Zip
Home Tel.()	Cell.()	Hav	ve you ever been a patient of our pr	ractice? 🛘 Yes 🗘 No
Referred By FIRST NAME		Has a family me	mber ever been a patient of our pro	actice? ☐ Yes ☐ No
	LAST NAME	thodontist		
	Pro	FIRST NAME eferred Pharmacy	LAST NAME Tel.()
Medical Dr. FIRST NAME Driver's Lic.#	Nearest relative not living wi		Tol ()
Employer	Bus Tel ()	FIRST NAME	ersonal Payment Type: Cash	
In case of emergency, please contact) Rela	
WHO WILL BE RESPONSIBLE FOR		1 el. (
		Othor		
☐ Self (If self, skip this section) ☐ Spou				Λαο.
Name FIRST NAME LAST NAME Tel.()Ce	5.5.# .ll. ()	F-mail	Birth Date	Age
	Apt.			Zip
Driver's Lic.#			Bus. Tel.()	·
SPOUSE OR OTHER GUARANT				
			Birth	Date
Name LAST NAME Street		City		
Tel. ()	Employer		Bus. Tel.()	
INSURANCE INFORMATION:				
Student:	ime 🛭 NotS	chool Name and Addre	SS SCHOOL NAME ADDRESS	
Marital Status: Married Divorc	ed 🛘 Widow 🖵 Single	☐ Legally Separated		CTATE 7ID
Marital Status: . □ Married □ Divorc Employed: □ Full Time □ Part Ti	-			STATE ZIP 10? Yes No
Employed:	ime □ Retired □ Not	☐ LegallySeparated	CITY	1O? ☐ Yes ☐ No
Employed: ☐ Full Time ☐ Part Ti	ime □ Retired □ Not	□ LegallySeparated PRIMARY M	спу Do you belong to a PPO or HM	1O? ☐ Yes ☐ No
Employed:	me Retired Not	PRIMARY M Employer Bus. Address	Do you belong to a PPO or HM	MPANY:
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Employed: Full Time Part Ti PRIMARY DENTAL INSURANCE Employer Bus. Address	COMPANY: CITY STATE ZIP Plan I.D. # TY STATE ZIP Name LAST NAME Sex: M	PRIMARY N Employer Bus. Address Bus. Tel.(Ins. Co. Name Address Tel.(Group # Relation	DO you belong to a PPO or HM MEDICAL INSURANCE CO DDRESS CITY Plan I.D. # Group Name Insured Party Birth Date	MPANY: STATE ZIP
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HEALTH HISTORY:

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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.

son	for today's office visit?				
				Yes	No
1.	Height	Weight	Are you in good health?		
2.	Have there been any	changes in your gene	eral health in the past year?		
3.	Are you under the ca	re of a physician?	Date of last visit		
	If so, for what are y	ou being treated?			
4.	Have you had any illi	ness, operation or be	en hospitalized in the past five years?	۵	
	If so, describe				
5.	Do you have unheale	ed / recurrent injuries	or inflamed areas, growths or sore spots in or around your mouth?	ū	
	If so, describe wher	е			
6.	Do you have a prost	hetic joint/ implant? <i>I</i> r	f so, describewhere		
7.	Have you had a heart	valve replacement or	vascular graft?	۵	
8.	Have you ever had ge	eneral anesthesia?		ū	
9.	Have you, or a family	member, had any un	usual or serious reactions to general anesthesia?	۵	۵
10.	Has a physician or pre	vious dentist recomm	nended that you take antibiotics prior to your dental treatment?	٥	

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO
11. Rheumatic fever?		
12. Damaged heart valves / mitral valve prolapse?		
13. Heart murmur?		
14. High blood pressure?		
15. Low blood pressure?		
16. Chest pain / angina?		
17. Heart attack(s)?		
18. Irregular heart beat?		
19. Cardiac pacemaker?		
20. Heart surgery?		
21. Pneumonia, bronchitis, chronic cough?		
22. Asthma?		
23. Hay fever / sinus problems?		
24. Snoring?		
25. Sleep apnea / CPAP?		
26. Difficult breathing / other lung trouble?		
27. Tuberculosis?		
28. Emphysema?		
29. Do you smoke or vape? If so, how much a day		
30. Do you use chewing tobacco?		
31. Blood transfusion?		
32. Blood disorder such as anemia?		
33. Bruise easily?		
34. Bleeding tendency / abnormal bleed?		
35. Hepatitis, jaundice, or liver disease?		
36. Infectious mononucleosis?		
37. Gallbladder trouble?		

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NO.	ΤE	ΤES	TES
38. Fainting spells?						
39. Convulsions / epilepsy?						
40. Stroke?						
41. Thyroid trouble?						
42. Diabetes?						
43. Low blood sugar?						
44. Kidney trouble?						
45. High cholesterol?						
46. Are you on dialysis?						
47. Swollen ankles / arthritis / joint disease?						
48. Osteoporosis / osteopenia?						
49. Osteonecrosis?						
50. Stomach / acid reflux?						
51. Contagious diseases?						
52. Sexually transmitted diseases?						
53. Problems with immune system? Possibly from medication / surgery, etc.						
54. Delay in healing?						
55. A tumor or growth?						
56. Cancer/radiation therapy/chemotherapy?						
57. Chronic fatigue / night sweats?						
58. Are you on a diet?						
59. A history of alcohol abuse?						
60. A history of marijuana or other drug use?						
61. Contact lenses?						
62. Eye disease / glaucoma?						
63. Mental health problems / anxiety / depression?						
64. A removable dental appliance?						
65. Pain or clicking of jaws when eating?						

WOMEN ONLY: (QUESTIONS 66-69)	WOMEN ONLY:	(QUESTIONS 66-69)
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66. Is there a possibility of pregnanc 67. Expected delivery date?	y?	٥	68. Are you taking hirth control pill?	
	veness of bir	th control pills. Cons	69. Are you taking birth control pill? ult your physician / gynecologist for assistance regarding other methods of	birth control.
ARE YOU NOW TAKING:	YES NO	NOTES	ARE YOU ALLERGIC TO, OR HAD A REACTION TO: YES NO 78. Local anesthetic (numbing meds.)?	NOTES
70. Any kind of medication, drug, pills?			79. Penicillin?	
71. Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba,			80. Other antibiotics?	
Aggrenox, Pradaxa, Fish oil)?				
72. Have you ever taken diet pills?			81. Sulfa drugs?	
73. Any natural product, herbal			82. Sodium pentothal / Valium /other tranquilizers?	
supplement or homeopathic remedy?			83. Aspirin? 84. Amoxicillin?	
74. Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphos-				
phonates such as Denosumab, Fosamax,			85. Codeine or other narcotics?	
Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the past 12 years?			86. Latex?	
75. Tranquilizers, sleeping pills, anti-depressan	ts and/or	narcotics on a	87. Soy?	
regular basis? If so, please list:	13, 4114/01	narcotics on a	88. Eggs / yolk? 89. Sulfites?	
76. If you are under the care of a physician for			90. Do you have any known allergies?	
recovering from drug addiction please sele are currently taking: Methadone o Su o Fentan Other:			91. Please list any allergies other than drug allergies:	
Treating doctor:				
77. Please list any medications you are current	ast Name			
Medication	Dosage	Frequency		
	1 1 1 1	- 4 7		
			92. Please list any other medication or antibiotic you are	allergic to:
			Medication / Antibiotic Name	u
			In the case of familia births and	
			Is there a family history of:	:
			☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthe	sola problems
If you are having surgery today , have you had	anything t	o eat or drink	Is this visit related to an accident? ☐ Yes ☐ No	
in the last 6 (six) hours? ☐ Yes ☐ No			If Yes, what type of accident? Automobile Work relative to the second secon	ated 🖵 Other
Who is driving you home?			Date of injury	
Is there any condition concerning your health t		ctor should	Insurance company handlingthe claim	
be told about? ☐ Yes ☐ No – If Yes, describe	•		Name of attorney / adjustor	
Do you wish to speak to the Dr. privately about	t anything?	P □ Yes □ No	Telephone number ()_	
, , ,	, ,			

Yes

No

Yes

No

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XX	X	X
Signature of patient (Parent or Guardian if Minor) Date	reviewed by	Date
Fees a We make every effort to keep down the cost of your care. You can help by manager depending upon special circumstances. An estimate of the charge for any dental and/or medical insurance we will be glad to fill out the proper forms,	r any procedure or surgery you may require	will be given to you upon request. If you have
Please remember that insurance is considered a method of reimbursing the pa fixed allowances for certain procedures and others pay a percentage of the clother balance not paid for by your insurance company. You will be response	harge. It is your responsibility to pay an	y deductible amount, co-insurance or any
X		X
Signature of patient (Parent or Guardian if Minor)		Date
This signature on file is my authorization for the release of information necessary otherwise payable to me. $\bf X$	ary to process my claim. I hereby authorize	payment to this doctor named of the benefits $old X$
Signature of patient: (Parent or Guardian if Minor)		Date
Aut I authorize my dentist and his / her designated staff, to perform an oral and ma I authorize the taking of all X–rays required as a necessary part of this examina in the course of my examination and treatment to my other doctors and/or insur my appointment. X Signature of patient (Parent or Guardian if Minor)	ition. In addition, if medically necessary, i au	thorize the release of any information acquired
I hereby acknowledge that a copy of this office's notice of Privacy Practice questions I may have regarding this Notice.	es has been made available to me. I have	been given the opportunity to ask any
X		X
Signature of patient (Parent or Guardian if Minor)		Date