

PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION

Today's Date: ____ / ____ / ____
Patient's Name-First: _____ MI _____ Last _____
Sex: M F Age: ____ Birth Date: ____ / ____ / ____
Marital Status: Married Single Divorced Child
Address: _____
City: _____ State: _____ Zip: _____
Social Security Number: _____
Driver's License Number: _____

PHONE NUMBERS

Home: () _____ Work: () _____
Cell: () _____
Best time/place to reach you: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____
Home: () _____ Work: () _____
Cell: () _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N). ALL ANSWERS ARE KEPT CONFIDENTIAL.

- 1) Are you in good health? Y N
- 2) Has there been any change in your general health in the past year? Y N
- 3) Date of last physical exam: _____
- 4) Are you now under a physician's care for a particular problem? If yes, for what? Y N

- 5) Have you had any serious illness, operations, or hospitalizations? If so, please describe: Y N

- 6) Have you had adverse effects from dental treatment?..... Y N
If so, what type: _____
- 7) Do you have or have you ever had any of the following:
A. Rheumatic fever or rheumatic heart disease Y N
B. Congenital heart disease Y N
C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, pacemaker, open heart surgery)? Y N

Dental Provider

Name of Dental Office: _____
Name of Dentist: _____
City: _____
Phone: () _____

Medical Provider

Name of Doctor's Office: _____
Name of Doctor: _____
City: _____
Phone: () _____

Other

Name of Referring DDS/MD: _____
If no referral, how did you hear about us? _____
Preferred Pharmacy (include phone #): _____

- D. Mitral Valve Prolapse? Y N
- E. HIV/ AIDS Y N
- F. Infectious Diseases? Y N
- G. Seizures, convulsions, epilepsy, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown? Y N
- H. Kidney disease/problems? Y N
- I. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) Y N
- J. Blood Clots Y N
- K. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily? Y N
- L. Liver disease (jaundice)? Y N
- M. Hepatitis A, B, or C? Y N
- N. Diabetes? Y N
- O. Thyroid disease/problems? Y N
- P. Arthritis? Y N
- Q. Stomach ulcers or colitis? Y N
- R. Glaucoma? Y N
- S. Frequent or recurring mouth sores? Y N
- T. Implants (heart valve, hip, knee) in your body? Y N
- U. Radiation (x-ray) treatment for cancer Y N
- V. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind/clench your teeth? Y N
- W. Sinus or nasal problems? Y N
- X. Any disease, drugs or transplant operation that may suppress your immune system? Y N
- Y. Recurring infection of any kind? Y N
- Z. Cancer Y N
- 8) Do you wear contact lenses? Y N
- 9) Do you smoke or chew tobacco? Y N
If yes, how much daily? _____
- 10) Do you use alcohol? Y N
If yes, how much daily? _____

Patient's Name: _____

11) Do you or might you have any condition or problem not listed here that you think the doctor should know about? Y N
If yes, please explain: _____

MEDICATIONS

1. Are you using or taking any aspirin or ibuprofen? Y N
If yes, how much daily? _____

2. Are you using or taking any drugs to assist in weight loss or weight gain? Y N
If yes, please specify: _____

3. Are you using or taking any street drugs? Y N
If yes, please specify: _____

4. Are you using or taking any other medications, pills, or drugs? Y N
If yes, please specify: _____

5. Are you taking or have you ever taken bisphosphonates (Fosamax, Actonel, Aredia, Boniva, Zometa for osteoporosis, or chemotherapy for multiple myeloma, etc)? Y N

ALLERGIES

1. Are you allergic to or have had an adverse reaction to ANY foods; i.e.: peanuts, milk, eggs or soy, etc.? Y N
If yes, please explain: _____

2. Are you allergic to or have you ever had an adverse reaction to ANY medications? Y N
If yes, please explain: _____

3. Have you ever had an adverse reaction to Novocain , latex, or rubber products? Y N
If yes, please explain: _____

FOR WOMEN ONLY

1. Are you pregnant or planning pregnancy? Y N
2. Are you taking birth control pills? * Y N
3. Are you taking hormone replacements? Y N

*If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your primary care physician for further guidance.

I UNDERSTAND THE IMPORTANCE OF PROVIDING A TRUTHFUL HEALTH HISTORY TO ASSIST MY DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPURTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR AND THE INFORMATION I HAVE PROVIDED HERE IS COMPLETE AND ACCURATE. ALSO, THE SIGNATURE BELOW IS ACKNOWLEDGEMENT THAT I HAVE RECEIVED NOTICE OF MY DOCTORS HIPAA PRIVACY PRACTICES.

Patient/Guardian's Signature: _____ Date: ____ / ____ / ____

Physician's Signature: _____ Date: ____ / ____ / ____

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the oral surgeon group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

Patient/Guardian's Signature: _____ Date ____ / ____ / ____

Patient's Name: _____

We are pleased to welcome you to our office. New patients are always appreciated. Our practice has grown as a result of its excellent relationship with our referring doctors and patients. As our patient, please feel free, at any time, to ask any questions or to express any concerns. In order to assist you in payment for your treatment the following options are listed. Please read them carefully and feel free to discuss them with us.

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time treatment is provided. For your convenience, financing is available upon credit approval. Please inquire with one of our patient representatives for details.

IF YOU HAVE INSURANCE, we will be happy to submit your claim to your insurance carrier for you. You are responsible at the time of your appointment for any deductible, co-payment, or benefits not covered by the insurance company. If the exact amount covered by your insurance cannot be determined at the time of your appointment, we request that you pay your deductible and one third (1/3) of the remaining cost of your treatment. Once our office has received payment from the insurance company, you will be billed with terms of 30 days for any amount still owed. If there is a payment credit, a check will be issued to you within 30 days.

PLEASE READ CAREFULLY: We will make every attempt to verify your insurance benefits for you. **PLEASE NOTE:** We can only estimate your coverage, dependent on information your insurance company provides us. Therefore, you may have a balance remaining after your claim has been paid. The amount paid by your insurance company may be based on the insurance company's own reduced fee schedule for oral and maxillofacial surgical services and may be less than actual charges, resulting in lower coverage. We have no control over this situation. Insurance companies rarely reimburse the full amount, paying 50-80% of the cost. This office quotes current fees well within usual and customary ranges. We are happy to file insurance claims for you as a courtesy; all fees quoted are the responsibility of the patient, regardless of insurance. **PLEASE BE ADVISED THAT WE CANNOT WAIVE CO-PAYMENTS. WE ARE REQUIRED BY LAW TO COLLECT ANY AND ALL CO-PAYMENTS.**

I hereby authorize and instruct _____ Insurance Company to make payment by check of any authorized insurance benefits on my behalf to the provider of service listed on the claim.

or

If my current policy prohibits direct payments to a medical provider, then I hereby instruct and direct you to make out all check payments to:

_____ (patient's name) and mail to the provider of service listed on the claim.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient/Guardian's Signature: _____ Date: _____ / _____ / _____