

ORAL & FACIAL SURGERY GROUP
PATIENT REGISTRATION AND INFORMATION FORM

Today's Date _____ Can we leave a phone message? _____
Have you ever been a patient with us before in one of our offices? _____ When? _____ Which office? _____

PATIENT INFORMATION:

Name: _____ Birthdate: _____ Age: _____ Sex: _____
Address: _____ Social Security #: _____
City: _____ State: _____ Zip: _____ Marital Status: S M D W Sep
Home Phone: _____ Employer: _____
Work Phone: _____ Address: _____
E-mail Address: _____ City _____ State _____ Zip _____
Emergency Phone & Contact _____ Dentist's Name _____
Referred by: _____ Physician's Name _____
What is the reason for your visit? _____ School (if student) _____

BILLING INFORMATION: (if different from patient) Soc. Sec. # _____ Birthdate _____

Name _____ Relationship to Patient _____
Address _____ Occupation _____
City _____ State _____ Zip _____ Employer _____
Home Phone _____ Address _____
Work Phone _____ City _____ State _____ Zip _____

MUST BE FILLED OUT COMPLETELY TO PROCESS CLAIMS: INSURANCE INFORMATION **DENTAL**

Subscriber's Name & Address _____ Employer _____
_____ Address _____
Insurance Company _____ City _____ State _____ Zip _____
Address _____ Birthdate _____
City _____ State _____ Zip _____ Group # _____
Subscriber's Soc. Sec.# or Policy ID# _____ Ins. Phone # _____

MUST BE FILLED OUT COMPLETELY TO PROCESS CLAIMS: INSURANCE INFORMATION **MEDICAL**

Subscriber's Name & Address _____ Employer _____
_____ Address _____
Insurance Company _____ City _____ State _____ Zip _____
Address _____ Birthdate _____
City _____ State _____ Zip _____ Group # _____
Subscriber's Soc. Sec.# or Policy ID# _____ Ins. Phone # _____

ADDITIONAL INFORMATION: **PLEASE GIVE X-RAYS AND/OR REFERRAL SLIP TO RECEPTIONIST**

Have X-rays been sent? _____ Is anyone with you today? _____
Is this visit accident related? _____
When did you last eat or drink? _____

**PLEASE ANSWER ALL QUESTIONS BY
CIRCLING Y (yes) N (no)**

ALL RESPONSES ARE KEPT CONFIDENTIAL

Please specify any YES answers

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. Are you now under a physician's care for a particular problem?.....Y N
4. Have you had any serious illnesses, operations or hospitalizations?
If so, describe:_____
5. Do you have or have you ever had:
 - a. Rheumatic fever or rheumatic heart disease? Y N
 - b. Congenital heart disease?.....Y N
 - c. Do you smoke?.....Y N
If Yes How Much?_____
 - d. Cardiovascular disease(heart trouble, heart attack, heart murmur, coronary artery disease, mitral valve prolapse, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker)?.....Y N
 - e. Lung disease (asthma, emphysema, chronic cough, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?.....Y N
 - f. Neurologic-psychological disorders (convulsions, epilepsy, seizures, fainting, psychiatric treatment, dizziness, nervous disorder or breakdown)?.....Y N
 - g. Blood disease (anemia, bleeding tendency, blood transfusion, do you bruise easily)?.....Y N
 - h. Liver disease (jaundice, hepatitis)?.....Y N
 - i. Kidney disease?.....Y N
 - j. Diabetes?.....Y N
 - k. Thyroid disease (goiter)?.....Y N
 - l. Arthritis?.....Y N
 - m. Stomach ulcers or colitis?.....Y N
 - n. Glaucoma?.....Y N
 - o. Frequent or recurring mouth sores?.....Y N
 - p. Implants placed anywhere in your body (heart valve, hip, knee)?.....Y N
 - q. Radiation (X-Ray) treatment for cancer?.....Y N
 - r. Clicking or popping of jaw joints, pain near ear, difficulty opening mouth, grind or clench teeth?....Y N
 - s. Sinus or nasal problems?.....Y N
 - t. Any disease drugs, or transplant operation that has depressed your immune system?.....Y N
 - u. Marijuana or other "street" drugs.....Y N

- v. Recurrent infections of any kind?.....Y N
- w. Problems with anesthesia?.....Y N
- x. Porphyria?.....Y N
- y. Problems with tooth extractions?.....Y N
- z. Cancer?.....Y N
- WOMEN: Birth control pills?.....Y N

6. DENTAL HISTORY

- a. When was your last checkup?_____
- b. Were X-rays taken?_____
- c. Do your gums bleed?_____
- d. Do you have sore or sensitive teeth?_____
- e. Do you have any sores, swellings, or fever blisters in your mouth?_____

7. Please list all MEDICATIONS you are taking:

8. Please list all FOOD and DRUG ALLERGIES:

9. Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?.....Y N

10. Do you wish to talk with the doctor privately about anything prior to your treatment?.....Y N

11. **WOMEN:** Are you pregnant or planning pregnancy? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE DOCTOR IN PROVIDING THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

Signature of person completing health history

Doctor's Signature

MEDICAL UPDATE: I have read my health history dated ____ / ____ / ____ and confirm that it adequately states past and present conditions.

_____	_____	_____	_____
Date	Exceptions or Changes	Patient's Signature	Doctor's Initials
_____	_____	_____	_____
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