ORAL & FACIAL SURGERY GROUP
PATIENT REGISTRATION AND INFORMATION FORM

Today's Date________________________

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:____________________

Cell Phone:____________________ City____________ State________ Zip________

Emergency Phone & Contact____________________ Dentist's Name____________________

Referred by:____________________ Physician's Name____________________

Email address?____________________ 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)

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. Problems with tooth extractions?.......... Y N
   y. Cancer?.. Y N
   WOMEN: Birth control pills?................... Y N

If we are administering general anesthesia to the patient (IV Sedation), the patient's ride MUST stay in the office during the entire visit.

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.

____
Signature of person completing health history

____
Doctor's Signature

Billing Consent & Payment Options

I give my permission to Oral & Facial Surgery Group, to bill my insurance carrier and if requested, provide any medical information to them. I also give my permission to use my x-rays and photographs for display. Your estimated out of pocket cost is due day of service. As a courtesy to you, we will file claims to your insurance carrier. However, any balance on your account after insurance has paid, will be your responsibility.

I certify that I have read and understand the above consent and payment options for treatment rendered.

____
Signature and Date

____
Print Name