

**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. Do you have sleep apnea or use a CPAP machine?Y N

**ALL RESPONSES ARE KEPT CONFIDENTIAL**

- w. Recurrent infections of any kind?.....Y N
- x. Problems with anesthesia?.....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.**

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

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