I. Patient Registration

☐ Mr. ☐ Mrs. ☐ Ms. _____ Birth Date _____
(Last) (First) (MI) MM/DD/YY

Marital Status: ☐ S ☐ M ☐ D Sex: ☐ M ☐ F Email Address _____

Address _____ City _____ State _____ ZIP _____

Home # _____ Cell # _____ Work # _____

Employer _____ Occupation _____

☐ Full-time ☐ Part-time Length of Employment: _____

Employer's Address _____ City _____ State _____ ZIP _____

II. Party Responsible for Payment

Name _____ Relationship _____ Phone # _____
(First) (Last)

Address _____ City _____ State _____ ZIP _____

III. Medical Insurance Information

Primary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____
(First) (Last)

PH Address _____

PH Employer _____

PH Relationship _____

PH Birth Date _____

ID# _____ Group # _____

SS# _____ (required only if used as ID#)

Secondary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____
(First) (Last)

PH Address _____

PH Employer _____

PH Relationship _____

PH Birth Date _____

ID# _____ Group # _____

SS# _____ (required only if used as ID#)

IV. Dental Insurance Information

Primary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____
(First) (Last)

PH Address _____

PH Employer _____

PH Relationship _____

PH Birth Date _____

ID# _____ Group # _____

SS# _____ (required only if used as ID#)

Secondary Insurance Co. _____

Claims Address _____

City/State/ZIP _____

Policy Holder (PH) _____
(First) (Last)

PH Address _____

PH Employer _____

PH Relationship _____

PH Birth Date _____

ID# _____ Group # _____

SS# _____ (required only if used as ID#)

V. Name of Person to Contact If Needed

Name _____ Relationship _____ Phone # _____

Address _____ City _____ State _____ ZIP _____

Dentist Who Referred You _____ Physician's Name _____
(First) (Last) (First) (Last)

I hereby authorize the Center for Oral and Maxillofacial Surgery, S.C. to disclose to the insurance companies named above all information contained in my health care records for the purpose of securing payment of any benefits that may be payable by said insurance companies for services rendered to me by the Center for Oral and Maxillofacial Surgery, S.C. The foregoing consent to the disclosure of my health care records shall remain in effect until such time as I deliver a written notice to the Center for Oral and Maxillofacial Surgery, S.C. stating that I have revoked my consent to the disclosure of my health care records to the insurance companies named above. If I have insurance coverage I understand that I am responsible for all charges on my account to be paid in full within 60 days following the date of service. Accounts more than 60 days past due will accrue a 1% monthly late payment charge. Accounts more than 90 days past due will be reviewed for collections unless arrangements, prior to surgery, have been made with the office administrator.

Signature of Responsible Party _____ Date _____

MEDICAL HISTORY – CONFIDENTIAL

Patient _____

Age _____ Height _____ Weight _____

Please Answer Each Question

1. What brings you to our office? _____
2. Have you been a patient in a hospital in the past 5 years? ☐ Yes ☐ No
3. For what reason? _____
4. Have you ever been under the care of a physician during the past 5 years? ☐ Yes ☐ No
5. For what reason? _____
6. Have you ever taken any kind of medication to increase bone density or prevent bone destruction for osteoporosis or cancer? ☐ Yes ☐ No

6a. List all medications (including herbal remedies) taken during the past year. _____

_____

_____

7. List all allergies to medications, foods, latex, etc. _____

_____

7a. What kind of reaction did you have to the medication(s)? _____

_____

7b. Preferred Pharmacy _____ Phone # _____

8. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
9. Select any of the following which you have had:

☐ heart trouble	☐ asthma	☐ epilepsy	☐ artificial joints or grafts e.g., hip or valve replacement
☐ congenital heart lesions	☐ cough	☐ motion sickness	
☐ heart murmur	☐ diabetes	☐ sleep apnea	Major surgery, Date/Year:
☐ high blood pressure	☐ tuberculosis	☐ mood disorder	_____
☐ anemia	☐ jaundice	☐ thyroid	_____
☐ rheumatic fever	☐ arthritis	☐ cholesterol	_____
☐ hepatitis	☐ stroke	☐ HIV/Aids	_____
			_____

10. Have you ever had any other serious illness? ☐ Yes ☐ No
11. Have you been diagnosed with any immune disorder? (Radiation treatment, Chemotherapy, Splenectomy, Steroid use) ☐ Yes ☐ No
12. Have you ever had any problems with your temporomandibular joints (jaw joints); e.g., noises, pain, or limited opening? ☐ Yes ☐ No
13. Do you smoke? ☐ Yes ☐ No
14. Are you pregnant? ☐ Yes ☐ No
15. Have you or anyone in your family had any problems with general anesthesia? ☐ Yes ☐ No
16. Has a member of your family been seen in our office before? ☐ Yes, Relative _____ ☐ No
17. Are you wearing contact lenses? ☐ Yes ☐ No

Signature _____ Date _____