

# PATIENT REGISTRATION & HEALTH HISTORY

Please complete the following confidential information:

Reason for Visit: \_\_\_\_\_

Who recommended this treatment? \_\_\_\_\_

How were you referred to us?  Dentist Dr. \_\_\_\_\_  Physician Dr. \_\_\_\_\_  
 Friend  Internet  Insurance  Other \_\_\_\_\_

Has anyone in your family ever been seen by a doctor in our practice?  Yes  No Name? \_\_\_\_\_

Date: \_\_\_\_\_ Chart #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Male  Female  Preferred Name \_\_\_\_\_  
Last First MI

Patient's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt City State Zip

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Married  Single  Divorced  Student  School: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Work: ( ) \_\_\_\_\_  
Last First MI

## PARENT/GUARANTOR INFORMATION

Parent/Guarantor: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ SSN #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## INSURANCE/PAYMENT INFORMATION

Please check the payment method most convenient for you: Check or Cash  Visa/Mastercard

Primary Insurance Dental  Medical  Additional Insurance Dental  Medical

Insurance Co.: \_\_\_\_\_ Insurance Co.: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_  
Last First Last First

Male  Female  Relationship to patient \_\_\_\_\_ Male  Female  Relationship to patient \_\_\_\_\_

Date of Birth: \_\_\_\_\_ of insured SSN #: \_\_\_\_\_ of insured SSN #: \_\_\_\_\_  
of insured of insured of insured of insured

Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

## ASSIGNMENT & RELEASE

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and that payment or payment arrangements must be made in accordance with terms of the financial policy of Atlanta Oral & Facial Surgery (AOFS), which is expressly made a part of this agreement and I acknowledge receiving and reading a copy of the Financial Policy.

I authorized payment of benefits to AOFS for services rendered under the terms of my insurance policy, but not to exceed the balance due of my account and for AOFS to release any medical or other information necessary to process insurance claims. I further authorized photocopies of this form to be valid as the original.

I acknowledge AOFS has made available their Notice of Privacy Practices according to 1996 HIPAA legislation. I have been given the opportunity to ask any questions I may have regarding this notice.

X \_\_\_\_\_ DATE \_\_\_\_\_

# HEALTH HISTORY

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | YES                      | NO                       |
| 1. Are you having pain or discomfort at this time?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you feel very nervous about having dental treatment?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a bad experience in the dental office?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever been a patient in the hospital during the past two years?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been under the care of a medical doctor during the past two years? | <input type="checkbox"/> | <input type="checkbox"/> |

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

6. Are you taking bisphosphonates? (medicine for bones)     Yes     No (example: Fosamax, Boniva, Actonel, Reclast)

Women: Are you pregnant?     Yes     No    If yes, what month? \_\_\_\_\_ Are you taking birth control pills?    Yes    No  
   

7. Have you taken any medicine or drugs during the past two years?          
 Are you now taking any medication, drugs, or pills?

If yes, please list: \_\_\_\_\_

8. Are you allergic or have you reacted adversely to any of the following medications?

Please check all that apply:

- |                                  |  |  |  |
|----------------------------------|--|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium            | <input type="checkbox"/> Local Anesthetic        |
| <input type="checkbox"/> Darvon  | <input type="checkbox"/> Erythromycin  | <input type="checkbox"/> Scopolamine       | <input type="checkbox"/> (Novocain or Xylocaine) |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tetracycline  | <input type="checkbox"/> Penicillin        | <input type="checkbox"/> Sleeping Pills          |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Percodan      | <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> (Nembutal/Seconal)      |

9. Are you aware of being allergic to any other medications or substance?

If yes, please list: \_\_\_\_\_

10. Have you had or have at present - Please check Yes or No:

- | YES                      | NO                       |                               | YES                      | NO                       | YES                             | NO                       |                          |  |
|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Failure                 | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                       | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive and/or AIDS               |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease or attack       | <input type="checkbox"/> | <input type="checkbox"/> | Cough                           | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A (Infectious)               |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina Pectoris               | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB)               | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B (serum)                    |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure           | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                          | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                  | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever                       | <input type="checkbox"/> | <input type="checkbox"/> | Yellow Jaundice                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever               | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble                   | <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Lesions      | <input type="checkbox"/> | <input type="checkbox"/> | Allergies or Hives              | <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever                 | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                        | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve        | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease                 | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker               | <input type="checkbox"/> | <input type="checkbox"/> | X-ray or Cobalt treatment       | <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery                 | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> | <input type="checkbox"/> | Fever Blisters                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joints (Hip, Knee) | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                       | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                        | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism                      | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizzy Spells               |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                        | <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine              | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Trouble                | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                        | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Treatment                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                        | <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints              | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Cosmetic Surgery              | <input type="checkbox"/> | <input type="checkbox"/> | Heavy Snoring or Sleep Apnea    | <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily                          |

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? | YES                      | NO                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you lost or gained more than 10 pounds in the past year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you currently taking any diet medication (Herbal, Phenfen, Redux)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are you on a special diet?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has your medical doctor ever said you have a cancer or tumor?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you smoke cigarettes, cigars or pipe tobacco products?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you use smokeless tobacco products (chewing tobacco, snuff)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have any disease, condition, or problem not listed?  | <input type="checkbox"/> | <input type="checkbox"/> |

Antibiotics may interfere with the action of Oral Contraceptives (OC). If you use OC and are prescribed an antibiotic, it is recommended that you use additional contraceptive precautions while taking the medicine and for the following seven (7) days.

I certify that the information provided is true and accurate to the best of my knowledge.

Signature of Patient (Parent or Guardian if minor) \_\_\_\_\_

Date \_\_\_\_\_