PATIENT REGISTRATION FORMS

The following information will help us serve you better. Please make every effort to fill out the information fully and accurately. Please be sure to complete all pages of this form. Your responses are held strictly confidential.

PERSONAL INFORMATION

Name_____Date of Birth____/____/_____Age_____Sex_____
S.S.#_____Height_____Weight_____Number of Children_____
Home Address_____
City_____State_____Zip_____
Where May We Leave A Message? ( ) Home_____( ) Cell_____
( ) Work_____( ) Spouse_____( ) Other_____
( ) Email_____
Employer_____Occupation_____
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Emergency Contact_____Relationship_____Phone_____
Who is responsible for charges?_____Phone_____

INSURANCE INFORMATION

MEDICAL

Primary_____
Policy Holder_____
Subscriber # _____
Group # _____Employer_____
S.S. # _____D.O.B.___/___/_____

Secondary_____
Policy Holder_____
Subscriber # _____
Group # _____Employer_____
S.S. # _____D.O.B.___/___/_____

DENTAL

Primary_____
Policy Holder_____
Subscriber # _____
Group # _____Employer_____
S.S. # _____D.O.B.___/___/_____

Secondary_____
Policy Holder_____
Subscriber # _____
Group # _____Employer_____
S.S. # _____D.O.B.___/___/_____

MEDICAL HISTORY

The medical history is an extremely important part of your consultation. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately. If you need some help, the staff will be glad to assist you.

WHY DID YOU SELECT OUR OFFICE? Please indicate all that apply:

( ) Patient Referral. May we ask who?_____May we acknowledge this referral? ( )Y ( )N
( ) Doctor Referral. May we ask who?_____May we acknowledge this referral? ( )Y ( )N
( ) General Reputation or Recommendation ( ) Speaking Engagement. Where?_____
( ) Website, which one?_____( ) Magazine, name?_____
( ) Other_____

Please check areas of interest:

[ ] Cosmetic Surgery (list areas of interest)_____
[ ] Skin Care
[ ] Dental Extractions / Wisdom Teeth Removal
[ ] Facial Trauma / Reconstruction
[ ] Orthognathic / Jaw Surgery
[ ] Dental Implant Evaluation
[ ] Pathology Evaluation
[ ] Other_____

List ALL prescription drugs you are taking_____

_____

Have you taken any medications for osteoporosis or bone disease?_____

_____

List ALL non-prescription drugs you take (I.e. aspirin, herbal medicines, etc.)_____

_____

List ANY diet pills you take, VERY IMPORTANT! (Can cause serious problems with anesthesia)_____

_____

List ANY drugs to which you are ALLERGIC to_____

_____

List ANY contact allergies including latex or other products_____

Please tell us about ANY serious illnesses you have had in the past: For example, heart disease, blood pressure problems, pulmonary disease, kidney disease, diabetes, thyroid trouble, stomach ulcers, etc._____

_____

Please list any operations you have had (including cosmetic surgery) Give approximate dates: _____

_____

_____

If applicable, please circle: Tubal ligation Hysterectomy Post-Menopausal **Pregnant**: **( )Yes ( )No _____wks**
Describe ANY difficulties you have had with anesthesia_____
Are there any hereditary disorders in your family that might be of significance? _____
Do you smoke? _____ If so, what form and how much? _____
Do you drink alcohol? Please check one: ( ) None ( ) Occasional ( ) Moderate ( ) Heavy_____
Do you now or have you ever had an addiction to controlled narcotics or street drugs? _____
Are you under a doctor's care? _____ If yes, who? _____

Please review the list below and check anything applicable. If you check any of the boxes below, please use the space at the bottom for any explanation that you think would be helpful. Please be as complete as possible.

( ) Severe dryness of the eyes
( ) Recurrent severe dizziness
( ) Chronic sinus problems or nasal blockage
( ) Paralysis of the face
( ) Chronic hoarseness
( ) Chest pain
( ) Chronic abdominal problems
( ) Blood in bowel movements
( ) Bleeding disorders, (you or anyone in your family)
( ) Menstrual disorder
( ) Problems with bones or joints
( ) Cancer
( ) Chronic skin condition
( ) Bad surgical result or unsatisfactory medical care
( ) Glaucoma or blurry vision
( ) Severe headaches
( ) Recurrent fever blisters
( ) Asthma or emphysema
( ) Shortness of breath
( ) Heart disease or high blood pressure
( ) Kidney or bladder problems
( ) Blood in urine or trouble urinating
( ) Easy bruising
( ) Abnormal lump or node
( ) Unexplained weight loss
( ) Emotional or Psychological problems
( ) Complications after surgery/anesthesia
( ) Artificial joints or heart valves

Please Explain:

_____

_____

_____

_____

I HAVE READ THIS FORM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.

Date this form was completed_____ **Patient Signature**_____

Reviewed by_____ **Date**_____