POTTSTOWN ORAL & MAXILLOFACIAL SURGERY ASSOCIATES, INC.

PATIENT REGISTRATION AND HEALTH HISTORY

Date: _____

Patient Information (CONFIDENTIAL)

Title: (Mr., Mrs., Ms.) First Name _____ Middle Init. ____ Last Name _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Birthdate _____ Age _____ Home Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse's: Name _____ Soc. Sec. # _____ Birthdate: _____

Employer: _____ Work Phone: _____

FAMILY DENTIST: _____ FAMILY PHYSICIAN: _____

Referred to Our Office by: _____ Is This Your First Visit? _____

Person to Contact in Case of Emergency _____ Phone _____

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME _____ SS# _____ Birth Date: _____

Employer _____

MOTHER'S NAME _____ SS# _____ Birth Date: _____

Employer _____

If parent's address is different from patient, please note: _____

If claim is for a dependent child, is child enrolled as a full-time student? ☐ Yes ☐ No

Name of School _____

Insurance Information

SURGICAL INSURANCE	DENTAL INSURANCE
Insurance Co. _____	Insurance Co. _____
Subscriber's Name _____	Subscriber's Name _____
Group No. _____	Group No. _____
ID / Agreement No. _____	ID / Agreement No _____

I authorize and request my insurance company to pay directly to Pottstown Oral & Maxillofacial Surgery insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

X _____

Signature of patient, parent if minor or guardian

Responsible Party

Person responsible for balance not covered by insurance? _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ SS# _____ Financial Institution _____

Employer _____ Work Phone _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No* *IF YES, COMPLETE:* Dental ☐ Surgical ☐

Insurance Company _____ ID# _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Name of Insured _____ Relationship to Patient _____

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Are you ALLERGIC or have you ever experienced any reaction to the following?

Local anesthetics (e.g. novocaine)	Yes ☐	No ☐	Aspirin or codeine	Yes ☐	No ☐
Barbiturates/sedatives/sleeping pills	Yes ☐	No ☐	Sulfa drugs	Yes ☐	No ☐
Penicillin/other antibiotics	Yes ☐	No ☐	Other allergies _____		

Are you taking any of the following?

Antibiotics/sulfa drugs	Yes ☐	No ☐	Tranquilizers	Yes ☐	No ☐
Blood thinners	Yes ☐	No ☐	Insulin/other diabetes drugs	Yes ☐	No ☐
Blood pressure medication	Yes ☐	No ☐	Digitalis/other heart medications	Yes ☐	No ☐
Thyroid medicine	Yes ☐	No ☐	Nitroglycerin	Yes ☐	No ☐
Cortisone/steroids	Yes ☐	No ☐	Aspirin	Yes ☐	No ☐
Antihistamines/allergy drugs/cold remedies	Yes ☐	No ☐	Are you taking birth control pills?	Yes ☐	No ☐
			Other medication _____		

If yes to any of the above, list **name** of medication and **dosage** below:

1. _____

2. _____

Are you presently under the care of a physician?	Yes ☐	No ☐	Do you use alcohol?	Yes ☐	No ☐
Are you presently pregnant?	Yes ☐	No ☐	Cocaine or other drugs?	Yes ☐	No ☐
Are you subject to prolonged bleeding?	Yes ☐	No ☐			
Are you subject to fainting spells?	Yes ☐	No ☐	Do you use tobacco?	Yes ☐	No ☐
Have you had surgery within the last 5 years?	Yes ☐	No ☐	How much _____		
Are you wearing contact lenses?	Yes ☐	No ☐			
Have you had any head, neck or jaw injuries?	Yes ☐	No ☐			

Have you **ever** been treated for:

Heart disease	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Asthma or hay fever	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Kidney diseases	Yes ☐	No ☐	Cough	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Joint replacement or implant	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Congenital heart lesions	Yes ☐	No ☐	AIDS or AIDS related complex	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	HIV positive	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Venereal disease	Yes ☐	No ☐

Comments: _____

_____

_____

I consent for myself (or my child) to the use of local and/or general anesthesia, depending upon the judgment of the doctor. I am aware of all probable complications of the surgery, anesthesia, and drugs, including swelling, discomfort, infection, bleeding, sinus involvement, numbness of lip, gum or tongue (possibly permanent). I hereby consent to such operations or treatment as may be deemed necessary in the diagnosis and treatment of my case.

To the best of my knowledge, all of the preceding answers are true and correct.

Signed _____ Date _____

Patient or nearest relative in the case when patient is a minor or physically or mentally incompetent.