BLUE RIDGE ORAL SURGERY

PATIENT REGISTRATION

PERSONAL AND CONFIDENTIAL INFORMATION

Patients Name ____________________ Date ____________

Street Address ____________________ Home Phone____________

P.O. Box #__________ City______________ State________ Zip __________

Cell Phone ______________ Alternate Phone ______________

Date of Birth __________ Social Security No.__________ Drivers License No.__________

Marital Status______________ Spouse Name______________

Dentist__________ Referred by __________ Physician __________

Emergency Contact ______________ Emergency Contact Phone # ______________

Relatives treated by Blue Ridge Oral Surgery ____________________

Your Employer______________ Work Phone______________ Student ❑ Y ❑ N

If under the age of 18, Person Responsible for Account____________________

Social Security No.__________ Date of Birth__________ Employed by__________

Employer Telephone No. ____________________

	MEDICAL INSURANCE	DENTAL INSURANCE
Company		
Insurance Claim Mailing Address		
Subscriber Name/Address		
Subscriber SS #		
Subscriber Birth Date		
Policy ID #		
Group #		

FEES ARE DUE AT THE TIME SERVICE IS RENDERED

I authorize release of any information relating to this claim to my insurance carrier. I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me. I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Updated ______________

Updated ______________

Updated ______________

Signature ____________________ Date______________

MEDICAL QUESTIONNAIRE

❑ Yes ❑ No 1. Are you taking any prescription, over the counter, herbal supplements or illicit drugs? (Include birth control pills and aspirin). **Please List:**____

Note: Birth control pills may be rendered ineffective if antibiotics (i.e. Penicillin, Erythromycin) are taken at the same time.

❑ Yes ❑ No 2. Are you allergic to any medicine? (Medicine that made you itch, swell or break out in a rash). **Please List:** (Such as Penicillin, Aspirin, codeine, etc.)____

❑ Yes ❑ No 3. Have you ever had a bad reaction to local or general anesthesia?

❑ Yes ❑ No 4. Have you ever taken any steroid or cortisone medicine?

❑ Yes ❑ No 5. Are you seeing a physician now or have you seen a physician within the last year for any medical problems?

❑ Yes ❑ No 6. Have you been hospitalized before for any illnesses, operations or injuries? **Please List:**____

❑ Yes ❑ No Have you had any blood transfusions or blood products in the last 5 years?

7. Place a check mark next to any of the following conditions you have or had:
   - ❑ a. Heart Trouble
   - ❑ b. Hearth Murmur
   - ❑ c. High Blood Pressure
   - ❑ d. Rheumatic Fever or Scarlet Fever
   - ❑ e. Chest Pain
   - ❑ f. Shortness of Breath

8. Place a check mark next to any of the following conditions you have or had:
   - ❑ a. Lung Problem
   - ❑ b. Asthma
   - ❑ c. Hey Fever
   - ❑ d. Emphysema
   - ❑ e. Chronic cough
   - ❑ f. Pneumonia
   - ❑ g. T.B.
   - ❑ h. Spitting up blood

❑ Yes ❑ No 9. Have you ever had any diseases of the stomach or gastro-intestinal tract? (Example: ulcer, colitis, diverticulitis)

❑ Yes ❑ No 10. Have you ever had any liver problems? (Example: Hepatitis, jaundice)

❑ Yes ❑ No 11. Have you ever had any diseases of the kidney or urinary tract? (Example: infections, kidney stones)

❑ Yes ❑ No 12. Have you ever been treated for diabetes? Are you taking insulin?

❑ Yes ❑ No 13. Have you ever been treated for thyroid problems?

❑ Yes ❑ No 14. Have you ever been treated for any tumor or cancer?

❑ Yes ❑ No 15. Have you ever been treated for epilepsy?

❑ Yes ❑ No 16. Have you ever been treated by a psychologist or psychiatrist?

❑ Yes ❑ No 17. Have you ever had radiation (X-ray) treatment for cancer?

❑ Yes ❑ No 18. Women: Are you pregnant or planning pregnancy?

❑ Yes ❑ No 19. Have you had any problems with excessive or unusual bleeding following surgery, including dental extractions?

❑ Yes ❑ No 20. Do you wear contact lenses?

❑ Yes ❑ No 21. Have you ever had anemia?

❑ Yes ❑ No 22. Do you smoke or use tobacco products?

❑ Yes ❑ No 23. Do you have any immune deficiency disorders or are you taking any immuno suppressant drugs?

❑ Yes ❑ No 24. Do you have any implanted body parts (i.e. hip joints, knee joints, heart valves, teeth)?

❑ Yes ❑ No 25. Do you wish to talk to the doctor privately about anything?

Signature____