

BLUE RIDGE ORAL & MAXILLOFACIAL SURGERY

PATIENT REGISTRATION

PERSONAL AND CONFIDENTIAL INFORMATION

Patient 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 _____

Referred by _____ Dentist _____ Physician _____

Emergency Contact _____ Emergency Contact Phone # _____

Who may we thank for your referral to our practice? _____

Your Employer _____ Work Phone _____ Student Y N

Person Responsible for Account _____

Social Security No. _____ Date of Birth _____ Employed by _____

Employer Telephone No. _____

	<u>MEDICAL INSURANCE</u>	<u>DENTAL INSURANCE</u>
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:
- | | |
|---|--|
| <input type="checkbox"/> a. Heart Trouble | <input type="checkbox"/> d. Rheumatic Fever or Scarlet Fever |
| <input type="checkbox"/> b. Heart Murmur | <input type="checkbox"/> e. Chest Pain |
| <input type="checkbox"/> c. High Blood Pressure | <input type="checkbox"/> f. Shortness of Breath |
8. Place a check mark next to any of the following conditions you have or had:
- | | |
|--|---|
| <input type="checkbox"/> a. Lung Problem | <input type="checkbox"/> e. Chronic cough |
| <input type="checkbox"/> b. Asthma | <input type="checkbox"/> f. Pneumonia |
| <input type="checkbox"/> c. Hay Fever | <input type="checkbox"/> g. T.B. |
| <input type="checkbox"/> d. Emphysema | <input type="checkbox"/> 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 _____