NORTHEAST ORAL SURGERY AND DENTAL IMPLANT CENTER

Patient Registration Form

PATIENT INFORMATION

Mr. Mrs. Ms. Dr.	First Name		MI		Last Name		
Gender	❑ Male ❑ Female	Birth Date		Age		Social Security #	
Address		City		State		ZIP Code	
Email		Home Phone		Cell Phone			
Preferred Form of Contact							
Marital Status	❑ Married	❑ Divorced	❑ Legally Separated	❑ Widow	❑ Single		
Employment Status	❑ Full Time	❑ Part Time	❑ Retired	❑ Not Employed			
Employer		Business Telephone					
Address		City		State		ZIP Code	
Student Status	❑ Full Time	❑ Part Time	❑ Not a Student	School Name			
Dentist Name		Telephone					
Medical Doctor		Telephone					
Orthodontist		Telephone					
Referred By							
Pharmacy information							

EMERGENCY CONTACT

First Name		Last Name	
Primary Telephone		Relationship to Patient	

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY

Primary Policy Holder	First Last				
Relation		Gender	❑ Male	❑Female	
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Group #		Policy ID #			

PRIMARY MEDICAL INSURANCE COMPANY

Primary Policy Holder	First Last				
Relation		Gender	❑ Male	❑ Female	
S.S. #		Birth Date			
Address					
City		State		ZIP Code	
Telephone					
Primary Policy Holder Employer					
Insurance Co. Name					
Address					
City		State		ZIP Code	
Telephone					
Group #		Policy ID #			

Do you have secondary insurance?	❑ Yes ❑ No	If yes, is it:	❑ Medical ❑ Dental
Primary Policy Holder	First Last	Relation	
Birth Date		S.S. #	
Secondary Insurance Co.		Policy ID#	
Address	City	State	ZIP Code
Telephone			

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HEALTH HISTORY

Please answer the following questions carefully and honestly. The information you provide is confidential and will assist us in providing you the best possible care. Please explain any YES answers.

Do you smoke, chew tobacco or vape?	❑ Yes	❑ No	Per day?		Per week?	
Do you smoke marijuana?	❑ Yes	❑ No	Per day?		Per week?	
Do you use alcohol?	❑ Yes	❑ No	Per day?		Per week?	

Hospitalizations and/or prior surgeries from childhood forward?	❑ Yes	❑ No
If yes, please describe when/why		
Reactions to any type of anesthesia?	❑ Yes	❑ No
If yes, please describe		
Any condition you wish to speak privately about with the Doctor?	❑ Yes	❑ No
Any disease or treatment that has lowered your immune system?	❑ Yes	❑ No
Any form of cancer?	❑ Yes	❑ No
Any unpleasant effect from previous dental care?	❑ Yes	❑ No
Are you required to pre-medicate with an antibiotic prior to dental treatment?	❑ Yes	❑ No
If yes, please state why		

Height		Weight	

MEDICATIONS

Please list all current prescription medications, non-prescription medications, vitamins, herbal supplements.

ALLERGIES/REACTIONS

Please list any allergies such as latex, codeine, penicillin, Novocain, tape, soy, eggs, nuts.

FOR WOMEN ONLY

Are you pregnant or trying to become pregnant?	❑ Yes	❑ No	Are you taking birth control pills?	❑ Yes	❑ No
Are you nursing?	❑ Yes	❑ No	Are you taking hormone replacement?	❑ Yes	❑ No

WARNING: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.

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Have you had or do you currently have the following:					
	Yes	No		Yes	No
Anemia			HIV		
Anxiety			Hoarseness		
Appetite Disorder			HPV		
Arthritis			Intestinal Disorder		
Artificial Joints			Jaw Joint Pain/Noise		
Asthma			Liver Disorder		
Bleeding Disorder			Measles		
Bronchitis			Mitral Valve Prolapse		
Chest Pain/Tightness			Mumps		
Chicken Pox			Nervous System Disorder		
Chronic Nasal Congestion			Night Sweats		
Coumadin/Blood Thinners			Osteoporosis Medication		
Depression			Pneumonia		
Diabetes			Psychiatric Treatment		
Diet Pills			Radiation Therapy		
Dislocated Joints			Recent Fevers		
Dizziness			Recurrent Mouth Sores		
Earache(s)			Seizures		
Emphysema			Shortness of Breath		
Fainting Spells			Sinus Disorders		
Fractured Bones			Sleep Apnea		
Gags Easily			Snoring		
Glaucoma			Stomach Ulcers		
Headaches			Thyroid Disease		
Hearing Changes			Treated for Alcohol Dependency		
Heart Murmur			Treated for Drug Dependency		
Heart Disease			Treated for Eating Disorder		
Heart Rhythm Changes			Treated for Sexually Transmitted Disease		
Heart Vessel Blockage			Tuberculosis		
Hepatitis A			Unexplained Weight Loss		
Hepatitis B			Vitamin Deficiency		
Hepatitis C			Wear Glasses/Contacts		
High Blood Pressure					

Please explain any YES answers or other medical problems not mentioned.

FORM COMPLETION

I honestly and accurately attest to the above medical history and authorize the release of this medical information, as necessary, for my treatment.

Patient Signature (Parent or Guardian if minor):	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	

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ACKNOWLEDGMENT OF ANESTHESIA & MEDICATION USE IN YOUR CARE

Please initial your understanding and acknowledgment of this policy below.

I acknowledge that certain medications that may be prescribed to me by my doctor at Northeast Oral Surgery and Dental Implant Center may alter my state of mental awareness and decision making. Depending on the type of anesthetic given, I understand the importance of adhering to the following:

- Refrain from driving a car.
- Refrain from operating machinery of any kind.
- Refrain from making important personal or business decisions.
- Refrain from drinking alcohol of any kind.
- Refrain from taking sedatives (prescribed by another doctor or over-the-counter).
- Refrain from taking different medications at the same time. To avoid nausea, wait 30-60 minutes between taking each medication.

_____

PATIENT FINANCIAL POLICY *Please initial your understanding and acknowledgment of this policy below.*

By initialing below, I agree to the terms of the Patient Financial Policy document.

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 establishes an individual's right to access and receive copies for their Protected Health Information (PHI). Additionally, this act provides for an individual to designate person(s) they are associated with, such as parent, guardian, spouse, child, etc. (this is in addition to their personal physician or dentist) to have access to their PHI. I hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices. I give my permission to discuss this account to the following:

1. _____

2. _____

INSURANCE REFERRAL WAIVER *Please initial your understanding and acknowledgment of this policy below.*

I have been informed by Northeast Oral Surgery and Dental Implant Center that based on the rules and regulations of my insurance policy; it is my responsibility to have a referral in place with my medical insurance company from my primary care physician.

I understand that if I do not have a referral in place, claims submitted by Northeast Oral Surgery and Dental Implant Center may not be paid and will be my financial responsibility.

_____

Patient Signature (Parent or Guardian if minor):		**Date**	

IF PATIENT IS A MINOR

Form signed by		**Relationship to Patient**	