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ORAL AND MAXILLOFACIAL SURGERY PC

Diplomates of The American Board of Oral and Maxillofacial Surgery

Registration and Health History

Name_____(male/female) Date of Birth_____ Age_____

Address_____ City_____ Zip_____

Home Phone#_____ Cell#_____ Work#_____ Pharmacy# _____

Social Security#_____ In case of an Emergency, contact _____

Marital Status (married / single) Family Dentist _____ Phone#_____

Student (full time / part time) Family Physician _____ Phone#_____

Please give receptionist any insurance cards, forms and x-rays. Email Address _____

Who may we thank for this referral?_____

Dental Insurance Carrier _____ Name of Insured _____

ID# _____ Group# _____ Insured's SS# _____

Relationship to Insured _____ Insured's Date of Birth _____

Medical Insurance Carrier _____ Name of Insured _____

ID# _____ Group# _____ Insured's SS# _____

Relationship to Insured _____ Insured's Date of Birth _____

Employer of Insured _____ (full time / part time / retired) Phone# _____

Address _____ City _____ Zip _____

Who is financially responsible for this account? _____ Phone#_____

Please Circle Yes or No, if you Have any of the following conditions:

Yes / No – Anemia	Yes / No – Thyroid Disease	Yes / No – Seizure Disorder
Yes / No – Heart Murmur (or MVP)	Yes / No – Asthma	Yes / No – Kidney Disease
Yes / No – High Blood Pressure	Yes / No – Diabetes	Yes / No – Might you be pregnant
Yes / No – Heart Disease	Yes / No – Are you nursing	Yes / No – History of Endocarditis
Yes / No – Use Oral Contraceptives	Yes / No – History of Hepatitis Type: A / B/ C	Yes / No – Sleep Apnea / Snoring
Yes / No – Artificial Joint / Heart Valve	Yes / No – History of radiation therapy: Head / Neck	Yes / No – Rheumatic Fever
Yes / No – Allergic to Latex, Soy or Egg	Yes / No – Nervous or Autoimmune Disorder	Yes / No – Tuberculosis
		Yes / No – Venereal Disease

Any other conditions, not listed above _____

Have you ever taken any of the following medications? (Fosamax /Actonel/Boniva/Aredia/Zometa/Prolia/Xqeva/Avastin) _____

List any antibiotics, anesthetics or other drugs you are allergic to _____

Have you taken any steroid medication in the past 2 (two) years? (Prednisone / Cortisone) _____

Have you ever had prolonged bleeding after a dental extraction or at any time? _____

List all prescription medications you are presently taking _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? _____

Do you have, or have you ever had clicking, popping or pain in your tempromandibular joints (TMJ)? _____

Have you been hospitalized in the past five years? _____ If yes, why? _____

Do you take aspirin on a daily basis? _____ If yes, why? _____

Are you under a physician's care presently? _____ If yes, why? _____

Have you ever been a drug or substance abuser? _____ Do you smoke? _____ How much? _____

Have you had **ANYTHING** to eat or drink in the past 6 (six) hours? _____

Is there anything you would like to discuss with the Doctor in private? _____

Doctor's Signature _____ Date _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other health care professionals who are involved in my care. I assign my insurance benefits to Nissman-Salin OMS unless otherwise indicated.

Signature _____ Date _____