

# PATIENT REGISTRATION FORM

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# Fallon

ORAL SURGERY AND IMPLANTOLOGY  
OF SYRACUSE

## I. Patient Information

Date: \_\_\_\_\_

Marital Status  Single  Married Family Dentist: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Title \_\_\_\_\_ Suffix \_\_\_\_\_ Sex:  M  F Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License: \_\_\_\_\_

## II. Employment Information

Patient's Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Responsible Party Name \_\_\_\_\_

Responsible Party Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ SS# \_\_\_\_\_

## III. Insurance Information

**PRIMARY:** Insurance Type:  Medical  Dental

**SECONDARY:** Insurance Type:  Medical  Dental

Subscriber \_\_\_\_\_ Name of Carrier \_\_\_\_\_

Subscriber \_\_\_\_\_ Name of Carrier \_\_\_\_\_

Group # \_\_\_\_\_ DOB \_\_\_\_\_

Group # \_\_\_\_\_ DOB \_\_\_\_\_

Agreement \_\_\_\_\_ Subscriber's SS # \_\_\_\_\_

Agreement \_\_\_\_\_ Subscriber's SS # \_\_\_\_\_

Plan \_\_\_\_\_ Policy # \_\_\_\_\_

Plan \_\_\_\_\_ Policy # \_\_\_\_\_

# HEALTH QUESTIONNAIRE FORM

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# Fallon

ORAL SURGERY AND IMPLANTOLOGY  
OF SYRACUSE

## I. General Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's office visit: \_\_\_\_\_

To Our Patients: Although oral surgeons treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential

Yes  No Are you in good health? Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Yes  No Have there been and changes in your general health in the past year?

Yes  No Are you under the care of a physician? Date of last visit: \_\_\_\_\_  
If YES, for what are you being treated? \_\_\_\_\_

Yes  No Have you had any illness, operation, or been hospitalized in the past five years?  
If YES please list: \_\_\_\_\_

Have you had or do you currently have ...	YES	NO	NOTES	Have you had or do you currently have ...	YES	NO	NOTES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Anesthetic Problems <sub>(Family History)</sub>	<input type="checkbox"/>	<input type="checkbox"/>		History of Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice, Hepatitis, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis, Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	
Chemotherapy or Radiation	<input type="checkbox"/>	<input type="checkbox"/>		Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>		Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Contagious Disease	<input type="checkbox"/>	<input type="checkbox"/>		Are you pregnant/nursing? <i>(estimated due date)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Problems with Immune System	<input type="checkbox"/>	<input type="checkbox"/>	
Delay in Healing	<input type="checkbox"/>	<input type="checkbox"/>		Prosthetic Knee/Hip etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Removable Dental Appliance	<input type="checkbox"/>	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Smoker	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Sore in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>		Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		TMJ-Pain & Clicking of Jaws	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease <sub>(Family History)</sub>	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur/Artificial Valves	<input type="checkbox"/>	<input type="checkbox"/>		Tumor or Growth	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>					

# HEALTH QUESTIONNAIRE FORM

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

## II. Allergy Information

	YES	NO	NOTES		YES	NO	NOTES
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>		Codeine or other Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>		Other Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Sodium Pentothal, Valium or other Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>		<i>(Please List)</i>			
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>		Allergies other than Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
				Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
				Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

## III. Medication Information

	YES	NO			YES	NO	NOTES
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Anticoagulant (Blood Thinners)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

List all medications, drugs, or pills:

**Note to Women:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

Yes  No Is there any condition concerning your health that the Doctor should be made aware of?  
If YES please explain:

Yes  No Is this visit related to an accident?  
Type of Accident: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his staff, responsible for errors or omissions that I have made in the completion of this form.

\_\_\_\_\_  
Patient's (or Legal Guardian's) Signature

\_\_\_\_\_  
Date

# CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## HIPPA CONTACT RELEASE FORM

Dear Patient,

In order to help us stay within the guidelines of HIPAA, please list below any Person/persons that you authorize to disclose information to regarding your Protected Health Information, including billing information. ( You do not need to list any of your doctors ).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

► **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

► **Notice of Privacy Practices:** You have the right to read or Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, At any time by contacting:**

**Contact Person:** Paul T., Timothy J., Paul Casey Fallon, and Kipp Slocum  
**Telephone:** (315) 451-6988  
**Fax:** (315) 453-0150  
**Address:** 4820 West Taft Road, Liverpool, NY, 13088

► **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

► **Fees & Payments:** Although we accept payments from your insurance company toward your account, you are responsible for your full account. I am aware that they accept Master Card and Visa. **WE ARE A NON-PARTICIPATING PROVIDER FOR ANY INSURANCE COMPANY.** I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. This signature on file is my authorization for the release of my information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

**SIGNATURE OF GUARANTOR:** \_\_\_\_\_ **Date:** \_\_\_\_\_

► **Signature:** I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. f

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# CONSENT FOR ANESTHESIA & EXTRACTION OF TEETH

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Patient's Name

Date

**Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.**

Extraction of teeth is an irreversible process and, whether routine or difficult, is a surgical procedure. As in any surgery, there are some risks. They include, but are not limited to, the following:

- \_\_\_\_\_ 1. Swelling and/or bruising and discomfort in the surgery area.
- \_\_\_\_\_ 2. Stretching of the corners of the mouth resulting in cracking or bruising.
- \_\_\_\_\_ 3. Possible infection requiring additional treatment.
- \_\_\_\_\_ 4. Dry socket – jaw pain beginning a few days after surgery, usually requiring additional care. It is more common from lower extractions, especially wisdom teeth.
- \_\_\_\_\_ 5. Possible damage to adjacent teeth. Especially those with large fillings or caps
- \_\_\_\_\_ 6. Numbness, pain, or altered sensations in the teeth, gums, lip tongue (including possible loss of taste sensation) and chin, due to the closeness of tooth roots (especially wisdom teeth) to the nerves which can be bruised or damaged. Almost always sensation returns to normal, but in rare cases, the loss may be permanent.
- \_\_\_\_\_ 7. Trismus – limited jaw opening due to inflammation or swelling, most common after wisdom tooth removal. Sometimes it is a result of jaw joint discomfort (TMJ), especially when TMJ disease already exists.
- \_\_\_\_\_ 8. Bleeding – significant bleeding is not common, but persistent oozing can be expected for several hours.
- \_\_\_\_\_ 9. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.
- \_\_\_\_\_ 10. Incomplete removal of tooth fragment – to avoid injury to vital structures such as nerves or sinus sometimes small root tips may be left in place.
- \_\_\_\_\_ 11. Sinus involvement – the roots of upper back teeth are often close to the sinus and sometimes a piece of root can be displaced into the sinus or an opening may occur into the mouth that may require additional care.
- \_\_\_\_\_ 12. Jaw fracture – while quite rare, it is possible in difficult or deeply impacted teeth.

# TREATMENT / PROGRESS NOTES

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Teeth to be removed: \_\_\_\_\_

Alternative treatment: \_\_\_\_\_

## ANESTHESIA:

**LOCAL ANESTHESIA:** (Novocain, Lidocaine, etc.) is given to block pain pathways in a localized area.

**LOCAL ANESTHESIA WITH NITROUS OXIDE:** Nitrous Oxide (or Laughing Gas) helps to decrease uncomfortable sensations and offers some degree of relaxation.

**LOCAL INTRAVENOUS SEDATION OR GENERAL ANESTHESIA:** alters your awareness of the procedure by producing sedative/amnesiac effects, or sleep.

Whichever technique you choose, the administration of any medication involves certain risks. These include:

1. Nausea and vomiting
2. An allergic or unexpected reaction. If severe, allergic reactions might cause more serious respiratory (lung) or cardiovascular (heart) problems which may require treatment.

In addition, there may be:

1. Pain, swelling, inflammation or infection of the area of the injection.
2. Injury to nerves or blood vessels in the area.
3. Disorientation, confusion, or prolonged drowsiness after surgery.
4. Cardiovascular or respiratory responses which may lead to heart attack, stroke, or death.

Fortunately, these complications and side effects are not common. Well-monitored anesthesia is generally very safe, comfortable, and well-tolerated. If you have any questions, PLEASE ASK.

I have read and understand the above and give my consent for:

- Local Anesthesia
- Local Anesthesia with Nitrous Oxide/Oxygen Analgesia
- Local Anesthesia with Intravenous Sedation or General Anesthesia

# TREATMENT / PROGRESS NOTES

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## CONSENT

I have read and understand the above and give my consent to surgery. I further state that if I have IV sedation or General Anesthesia, that **I HAVE NOT HAD ANY SOLIDS OR LIQUIDS BY MOUTH FOR SIX (6) HOURS PRIOR TO SURGERY. TO DO OTHER WISE MAY BE LIFE-THREATENING!** I agree not to drive myself home and to have a responsible adult accompany me until I am recovered from my medications. I have given a complete and truthful medical history, including all medications, drug use, pregnancy, etc. I certify that I speak, read and write English.

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Patient's (or Legal Guardian's) Signature

Date

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Doctor's Signature

Date

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Witness' Signature

Date

