PATIENT REGISTRATION FORM

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

Subscriber ____________ Name of Carrier ____________

Group # ____________ DOB ____________

Agreement ____________ Subscriber's SS # ____________

Plan ____________ Policy # ____________

SECONDARY: Insurance Type: ☐ Medical ☐ Dental

Subscriber ____________ Name of Carrier ____________

Group # ____________ DOB ____________

Agreement ____________ Subscriber's SS # ____________

Plan ____________ Policy ____________

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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
Anemia	☐	☐	
Anesthetic Problems(Family History)	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bleeding Tendency	☐	☐	
Blood Transfusion	☐	☐	
Bronchitis, Chronic Cough	☐	☐	
Cancer	☐	☐	
Cardiac Pacemaker	☐	☐	
Chemotherapy or Radiation	☐	☐	
Contact Lenses	☐	☐	
Contagious Disease	☐	☐	
Convulsions	☐	☐	
Delay in Healing	☐	☐	
Diabetes	☐	☐	
Dialysis	☐	☐	
Difficulty Breathing	☐	☐	
Emphysema	☐	☐	
Epilepsy	☐	☐	
Eye Disease	☐	☐	
Fainting Spells	☐	☐	
Gallbladder Trouble	☐	☐	
Hay Fever/Sinus Problems	☐	☐	
Heart Attack/Chest Pain	☐	☐	
Heart Disease(Family History)	☐	☐	
Heart Murmur/Artificial Valves	☐	☐	
Heart Surgery	☐	☐	

Have you had or do you currently have …			
	YES	NO	NOTES
High Blood Pressure	☐	☐	
History of Drug/Alcohol Abuse	☐	☐	
Infection	☐	☐	
Irregular Heart Beat	☐	☐	
Jaundice, Hepatitis, Liver Disease	☐	☐	
Kidney Trouble	☐	☐	
Low Blood Pressure	☐	☐	
Low Blood Sugar	☐	☐	
Malignant Hyperthermia	☐	☐	
Mental Health Problems	☐	☐	
Mitral Valve Prolapse	☐	☐	
Are you pregnant/nursing?	☐	☐	
(*estimated due date)*			
Problems with Immune System	☐	☐	
Prosthetic Knee/Hip etc.	☐	☐	
Removable Dental Appliance	☐	☐	
Rheumatic Fever	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Smoker	☐	☐	
Sore in Mouth	☐	☐	
Stomach Ulcers	☐	☐	
Stroke	☐	☐	
Swollen Ankles	☐	☐	
Thyroid Trouble	☐	☐	
TMJ-Pain & Clicking of Jaws	☐	☐	
Tuberculosis	☐	☐	
Tumor or Growth	☐	☐	

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Name: ______________________________ Date: ______________

I. Allergy Information

	YES	NO	NOTES			YES	NO	NOTES
Local Anesthetic	☐	☐			Codeine or other Narcotics	☐	☐	
Penicillin	☐	☐			Other Medications	☐	☐	
Sodium Pentothal, Valium or other Tranquilizers	☐	☐			*(Please List)*			
					Allergies other than Drug Allergies	☐	☐	
Aspirin	☐	☐			Latex Allergy	☐	☐	
					Food Allergies	☐	☐	

II. Medication Information

	YES	NO				YES	NO	NOTES
Birth Control	☐	☐				☐	☐	
Anticoagulant (Blood Thinners)	☐	☐				☐	☐	

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