PATIENT REGISTRATION FORM
Bay Area Oral and Facial Surgery

Patient's Name _____ **Today's Date**: _____
Last First MI

Single:___ Married ___ Divorced ___ Minor ___ Age ____ Birth date_____ Male □ Female □
Street Address: _____ Social Sec. No_____
City: _____ State _____Zip_____ Telephone: HOME _____
Driver's License No:_____ WORK_____
Present Complaint: _____ Patient/Parent employed by:_____
Who referred you to this office? _____ Employer's Address :_____
Referring doctor's name & phone: _____
_____ Spouse/Parent's Name:_____
Contact Person not living with you, with address and phone_____ Spouse's Social Sec No:
_____ _____
Who is responsible for this account? If patient is minor, please give names of both parents: Spouse's Employer:_____
_____ Spouse's Position/Occupation: _____

Primary Insurance Coverage Information:
Insured's Name _____
Insured's Date of Birth _____
Soc.Sec. No._____
Name of Insurance Co. _____
Address: _____
_____
Phone:_____ Plan/ID No.:_____
□ Medical □ Dental

Primary Dental Insurance Information:
Insured's Name _____
Insured's Date of Birth _____
Soc. Sec. No. _____
Name of Insurance Co. _____
Address_____
_____
Phone: _____ Plan/ID No: _____
□ Medical □ Dental

Method of Payment:
Credit Card □ Cash □ Check □
□ Other _____

PLEASE ANSWER ALL QUESTIONS BY CIRCLING YES (Y) OR NO (N) All answers are kept confidential

1. Has there been any change in your general health in the past year? Y N
2. Date of last physical exam: _____
3. Are you now under a physician's care for a particular problem? Y N
   If yes, for what? _____
   _____
4. Have you had any serious illnesses, operations or hospitalizations in the last 5 years? If so, describe:_____ Y N
   _____
5. Have you had any adverse effects from dental treatment? Y N
6. Have you or anyone in your immediate family had difficulty with general anesthesia? Y N
7. Do you snore while sleeping or have been diagnoses with sleep apnea? Y N
8. Do you wear contact lenses? Y N
9. Do you smoke or chew tobacco? How much daily?_____ Y N
10. Do you use alcohol? How much?
    _____
11. Have you ever sought professional care for drug abuse, alcoholism, or emotional disorders? Y N
12. WOMEN: Are you pregnant or planning pregnancy? Y N
    Are you taking any birth control pills? Y N
    Are you taking hormone replacements? Y N
    Are you nursing? Y N
    If yes, how many months: _____

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13. Do you have or have you ever had any of the following:

A. Rheumatic fever or rheumatic heart disease?	Y	N
B. Congenital heart disease?	Y	N
C. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary artery disease, angina, high blood pressure, low blood pressure, stroke, palpitations, heart surgery, pacemaker installed), damaged heart valve?	Y	N
D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, sever coughing?	Y	N
E. Seizures, convulsions, epilepsy, fainting, psychiatric treatment,dizziness, nervous disorder or breakdown?	Y	N
F. Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Y	N
G. Liver disease (jaundice, hepatitis)?	Y	N
H. Kidney disease?	Y	N
I. Diabetes?	Y	N
J. Thyroid disease?	Y	N
K. Arthritis, osteoporosis, joint disease?	Y	N
L. Stomach ulcers or colitis?	Y	N
M. Glaucoma?	Y	N
N. Frequent or recurring mouth sores?	Y	N
O. Implants placed in your body (heart valve, hip, knee)?	Y	N
P. Radiation (x-ray), surgery, oral drug or chemotherapy treatment for cancer?	Y	N
Q. Clicking or popping of jaw joint, pain near ears, difficulty in opening mouth; grind or clench your teeth ?	Y	N
R. Sinus or nasal problems?	Y	N
S. Any disease, drugs or transplant operation that may suppress your immune system? AIDS? HIV?	Y	N
T. Recurring infections of any kind?	Y	N

14. Are you using or taking any of the following:

A. Tagamet?	Y	N
B. Thyroid medications	Y	N
C. Antibiotics or sulfa drugs?	Y	N
D. Anticoagulants/blood thinners?	Y	N
E. High blood pressure medicine?	Y	N
F. Steroids, cortisone, etc?	Y	N
G. Tranquilizers (valium, etc)?	Y	N
I. Digitalis, inderal, nitroglycerine, calcium blockers, procardia or other heart medication?	Y	N
J. Aspirin or ibuprofen (motrin, naprosyn, etc)?	Y	N
K. Antihistamines or other decongestants (seldane, etc)?	Y	N
L. Drug (s) to assist in weight loss or weight gain?	Y	N
M. Any other medications, pills or drugs, including “street” drugs?	Y	N

If yes, please specify: _____
_____

14. Are you allergic or have a bad reaction to:

A Local anesthesia (novocane, etc)?	Y	N
B Penicillin, amoxicillin, cephalosporins, or other antibiotics?	Y	N
C Barbiturates, sedatives, etc?	Y	N
D Aspirin or ibuprofen?	Y	N
E Codeine or other pain killers?	Y	N
F Latex or rubber products?	Y	N
G Soybeans?	Y	N
H Eggs?	Y	N
I Other allergies or reactions?	Y	N

If yes, please specify: _____

15. Do you have any other disease, condition or problem not listed here that you think the doctor should know about? Y N

If yes, please specify:_____
_____

16. Do you wish to talk with the doctor privately about anything? Y N

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. I have had the opportunity to discuss my health history with my doctor and the information I have provided here is complete and accurate.

Patient/Guardian'sSignature_____ Date_____

Physician's Signature_____ Date_____