Patient Registration Form

Foothill Oral Surgery Center

About You

The Patient

Last Name _____ First Name _____ Middle Initial___ Prefer To Be Called_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail address _____ SS#_____

Male ☐ Female ☐ Age_____ Date of Birth _____ ☐Single ☐Married ☐ Widowed ☐Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address_____ Bus. Phone_____

Is patient a full-time college student? Yes ☐No ☐ Name of school _____City_____ State_____

Have you or a family member been to our office before? Who and When? _____

Patient Account Information

Person Responsible for Account

Last Name _____ First Name _____ Relation to Patient _____ Date of Birth _____

SS# _____ Address (if different from patient) _____

City _____ State _____Zip _____ Home Phone_____

Person Responsible Employed by_____Occupation_____

Business Address_____ Bus. Phone _____Cell Phone_____

Dental Insurance Information

Primary Dental Insurance

Dental Insurance Co. Name_____ Phone _____

Insurance Co. Address _____ Group No._____

Subscriber's Name _____ Relation to Patient _____ Date of Birth _____

Subscriber's Address (if different than patient)_____ SS# _____

City _____ State_____ Zip _____ Home Phone_____

Subscriber Employed by _____ Bus. Phone _____

Is patient covered by additional dental insurance? Yes ☐ No☐

Secondary Dental Insurance

Dental Insurance Co. Name _____ Phone _____

Insurance Co. Address _____ Group No. _____

Subscriber's Name _____ Relation to Patient _____ Date of Birth _____

Subscriber's Address (if different than patient)_____ SS# _____

City _____ State_____ Zip _____ Home Phone_____

Subscriber Employed by _____Bus. Phone _____

In Event of Emergency

Person To Contact Name _____Relation to Patient _____

Home Phone _____ Bus Phone _____Cell Phone _____

Dental History Information

Who referred you to our office? (Dentist Name / or Person) _____ I have been seen by him/her for _____ months/years.

Do your gums bleed when you brush?	Y	N	Do you know about dental implants?	Y	N
Do you have pain or clicking in your jaw joints?	Y	N	Do you know someone who has dental implants?	Y	N
Do you grind or clench your teeth?	Y	N	Are you happy with the way your teeth function?	Y	N
Do you have missing teeth?	Y	N	Are you happy with the way your teeth look?	Y	N
Date of last dental examination with your dentist? _____			Are you having pain or discomfort at this time	Y	N

How would you describe your current dental condition and reason for your visit_____

Medical Information

Have you been a patient in the hospital during the past two years? What for?_____ Y☐ N☐
Have you been under the care of a medical doctor during the past two years? What for? _____ Y☐ N☐

Physician' name _____ Phone _____

Address _____City _____ Fax _____

Have you taken any medication or drug(s) during the past two years? Y☐ N☐ List _____

Are you now taking any current medication , herbs or drugs? Y☐ N☐ List (include dose and regimen):

_____ _____ _____ _____

_____ _____ _____ _____

Are you **SENSITIVE OR ALLERGIC** to any medication or anesthetics? Y☐ N☐ List

_____ _____ _____ _____

Are you **SENSITIVE OR ALLERGIC** to any of the following?: (please circle) LATEX SOY EGGS

Do you smoke tobacco products/ or have previous history of use? Y☐ N☐ If yes, how many packs/day? _____ How many years? _____

Do you use, or have you ever used recreational drugs? Y☐ N☐ If yes, what drug(s)? _____

Please check YES or NO indicating whether you Have Had or Have at present any of the following conditions or symptoms?

	Y	N		Y	N		Y	N		Y	N
High Blood Pressure	___	___	Cosmetic Surgery	___	___	Cancer (Tumor)	___	___	Blood Transfusion	___	___
Stroke	___	___	Limited Jaw Opening	___	___	X-Ray/Cobalt Treatment	___	___	Drug Addiction	___	___
Heart Disease	___	___	Pain/Noise in Jaw Joints	___	___	Chemotherapy	___	___	Venereal Disease	___	___
Angina Pectoris	___	___	Alcoholism	___	___	Arthritis	___	___	Cold Sores	___	___
Pacemaker	___	___	Emphysema	___	___	Rheumatism	___	___	Epilepsy or Seizures	___	___
Rheumatic Fever	___	___	Persistent Cough	___	___	Steroids (Cortisone)	___	___	Fainting or Dizzy Spells	___	___
Heart Murmur	___	___	Tuberculosis (TB)	___	___	Glaucoma	___	___	Depression, Nervousness	___	___
Scarlet Fever	___	___	Asthma	___	___	Bruise Easily	___	___	Psychiatric Treatment	___	___
Artificial Joint	___	___	Hay Fever	___	___	Liver Disease	___	___	Blood Disorder	___	___
Anemia	___	___	Sinus Trouble	___	___	Hepatitis	___	___	Hemophilia	___	___
Kidney Trouble	___	___	Allergies or Hives	___	___	Yellow Jaundice	___	___	Sickle Cell Disease	___	___
Ulcers	___	___	Diabetes	___	___	AIDS	___	___	Hypoglycemia	___	___
Porphyria	___	___	Thyroid Disease	___	___	Developmentally Disabled	___	___			

Notes (For Doctor Use Only):

Do you have any disease or problem not listed above?_____	Y☐	N☐
Do you currently wear contact lenses?	Y☐	N☐
Have you ever had any excessive bleeding requiring special treatment?	Y☐	N☐
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest?	Y☐	N☐
Do your ankles swell during the day?	Y☐	N☐
Do you sleep with more than two pillows under your head?	Y☐	N☐
Have you lost or gained more than 10 pounds during the past year?	Y☐	N☐
Are you on a special diet?	Y☐	N☐
Have you ever taken or do you take bisphonates (i.e., Fasomax)?	Y☐	N☐
Males: Have you ever taken Viagra?	Y☐	N☐
Females: Are you pregnant? (Surgery/Medication may cause birth defects/miscarriage)	Y☐	N☐
Females: Do you wish to consult your physician to rule out pregnancy?	Y☐	N☐
Females: Are you currently using birth control pills?	Y☐	N☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform this office immediately at the next appointment without fail.

Signature of Patient, Parent or Guardian _____ **Date** _____