NEPA Oral and Maxillofacial Surgery – Patient Registration Form

Patient Name _____ (FIRST NAME / LAST NAME) Age _____ Birth Date _____ Sex: M F

Home Address _____ Social Security Number _____

City _____ Height _____ Weight _____

State _____ Zip Code _____

Home Phone _____ ☐ Student ☐ Part Time ☐ Full Time

Cell Phone _____ School Name _____

Place of employment _____ Employer's Phone _____

Person responsible for bills _____ (FIRST NAME / LAST NAME) Relationship _____

Address _____ (STREET ADDRESS / CITY / STATE / ZIP CODE) Phone _____

Family Dentist _____ (FIRST NAME / LAST NAME) Family Doctor _____ (FIRST NAME / LAST NAME)

Referred By _____ (FIRST NAME / LAST NAME) Pharmacy _____ (NAME / CITY)

Do you have x-rays? ☐ Dentist Mailed ☐ Dentist Emailed ☐ with Patient ☐ None

INSURANCE – PLEASE PRESENT CARDS TO SECRETARY TO COPY

Primary *DENTAL* Insurance: _____ Member I.D.: _____

Subscriber Name: _____ (FIRST NAME / LAST NAME) Group #: _____

Relationship to Patient: _____ Employer: _____ Birth Date: _____

Secondary *DENTAL* Insurance: _____ Member I.D.: _____

Subscriber Name: _____ (FIRST NAME / LAST NAME) Group #: _____

Relationship to Patient: _____ Employer: _____ Birth Date: _____

Primary *MEDICAL* Insurance: _____ Member I.D.: _____

Subscriber Name: _____ (FIRST NAME / LAST NAME) Group #: _____

Relationship to Patient: _____ Employer: _____ Birth Date: _____

Secondary *MEDICAL* Insurance: _____ Member I.D.: _____

Subscriber Name: _____ (FIRST NAME / LAST NAME) Group #: _____

Relationship to Patient: _____ Employer: _____ Birth Date: _____

I verify all information provided is correct to the best of my knowledge

Signature: _____ Date: _____

NEPA Oral and Maxillofacial Surgery - Medical History & Health Questionnaire

Patient's Name _____ Date _____ Height _____ Weight _____ Age_____

1. Are you in good health?	YES	NO
2. Are you now under the care of a physician?	YES	NO
If so, for what condition?		
3. Are you taking any prescription, non-prescription or herbal medications?	YES	NO
4. Are you allergic to:		
a. Any drugs or medications	YES	NO
b. Local anesthesia (Novacaine, etc.)	YES	NO
c. Latex or rubber products	YES	NO
d. Soybeans or soy products	YES	NO
5. Have you ever had any operations?	YES	NO
6. Have you ever received general anesthesia?	YES	NO
If yes, did you have any adverse reactions?	YES	NO
7. WOMEN - Are you pregnant or nursing?	YES	NO
8. Do you smoke?	YES	NO
If so, how much per day?		
9. Do you drink alcohol?	YES	NO
If so, how often?		
10. Do you wear contact lens?	YES	NO
11. Have you received radiation or chemotherapy?	YES	NO
If yes, when?		
12. Do you have a history of bleeding problems?	YES	NO
13. **HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:**		
a. HEART TROUBLE	YES	NO
Congenital heart disease	YES	NO
Angina (chest pain)	YES	NO
Heart attack	YES	NO
Heart surgery	YES	NO
Pacemaker / Defibrillator	YES	NO
Damaged heart valve or heart murmur	YES	NO
High blood pressure	YES	NO
b. LUNG DISEASE	YES	NO
Asthma	YES	NO
Chronic bronchitis	YES	NO
Emphysema	YES	NO
Shortness of breath	YES	NO
Tuberculosis	YES	NO
c. DIABETES	YES	NO

d. THYROID DISEASE	YES	NO
e. SLEEP APNEA	YES	NO
f. NERVOUS DISORDER	YES	NO
Stroke	YES	NO
Seizure	YES	NO
Epilepsy	YES	NO
Headaches	YES	NO
Psychiatric care	YES	NO
g. BLOOD DISORDER	YES	NO
Anemia	YES	NO
Bleeding problems	YES	NO
Bleed/Bruise easily	YES	NO
Porphyria	YES	NO
h. KIDNEY DISEASE	YES	NO
Dialysis treatment	YES	NO
i. LIVER DISEASE	YES	NO
Hepatitis	YES	NO
j. IMMUNE SYSTEM	YES	NO
HIV/AIDS	YES	NO
Organ transplant	YES	NO
Other:		
k. SINUS DISEASE	YES	NO
l. VENEREAL DISEASE	YES	NO
m. BONE DISEASE	YES	NO
Osteoporosis	YES	NO
Medications for Osteoporosis, including: Bisphosphonate (Fosomax, Boniva, Zometa, Actonel, Aredia, Risedronate, Reclast)	YES	NO
Artificial joint replacement	YES	NO
Back or neck injury	YES	NO
TMJ or jaw problems	YES	NO
14. Have you been told by your physician that you are at risk for sudden cardiac arrest syndrome/prolonged QT syndrome?	YES	NO
15. Has anyone in your family died under the age 50 due to an unknown cause?	YES	NO
16. Do you suffer from lightheadedness/dizziness	YES	NO
17. Have you ever used recreational or street drugs?	YES	NO
18. Do you have a disease/condition not listed?	YES	NO
If yes, please list		

List current medications: _____

_____

List past surgeries: _____

Allergies _____