



Oral Plastic Surgery Associates, P. A. Registration Form

PATIENT INFORMATION

Date _____
 SS # _____
 Patient _____
 Address _____

 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F Age _____
 Birthdate _____
 Married Widowed Single
 Separated Divorced Minor

Occupation _____
 Patient Employer/School _____

Spouse's Name _____
 Birthdate _____
 SS# _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

PHONE NUMBERS

Home _____
 Work _____ Ext _____
 Cell Phone _____
 Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____
 Phone number _____
 Relationship _____

DENTAL INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group# _____
 Is Patient covered by additional insurance? Y N
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group# _____

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to
 (Name of Insurance Co.)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclosure such information to the above-named Insurance Co. and their agents, for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Patient Signature, Parent or Guardian

 Please Print Name of Patient, Parent or Guardian

 Date Relationship to Patient

Reason for your visit today _____

DENTAL HISTORY

Former dentist _____ City/State _____

Date of last dental visit _____ Date of last dental x-ray _____

Circle on **Yes** or **No** to indicate if you have had any on the following:

Bad Breath	Y N	Food collection between the teeth	Y N	Pain around ear	Y N
Bleeding gums	Y N	Grinding teeth	Y N	Periodontal treatment	Y N
Blisters	Y N	Gums swollen or tender	Y N	Sensitivity to cold	Y N
Burning sensation on tongue	Y N	Jaw pain or tiredness	Y N	Sensitivity to heat	Y N
Chew on one side of mouth	Y N	Lip or cheek biting	Y N	Sensitivity to sweets	Y N
Cigarette, pipe, or cigar smoking	Y N	Loose teeth or broken fillings	Y N	Sensitivity when biting	Y N
Clincking or popping jaw	Y N	Mouth breathing	Y N	Sores or growths in your mouth	Y N
Dry mouth	Y N	Mouth pain, brushing	Y N	How often do you floss? _____	
Finger nail biting	Y N	Orthodontic treatment	Y N	How often do you brush? _____	

HEALTH HISTORY

Physician's Name: _____ Phone _____ Last visit _____

_____ Phone _____ Last visit _____

Please circle **Yes** or **No** to indicate if you have had any of the following:

AIDS/HIV	Y N	Epilepsy	Y N	Respiratory Disease	Y N
Anemia	Y N	Fainting or dizziness	Y N	Rheumatic Fever	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Scarlet Fever	Y N
Artificial Heart Valves	Y N	Headaches	Y N	Shortness of Breath	Y N
Artificial Joints	Y N	Heart Murmur	Y N	Sinus Trouble	Y N
Asthma	Y N	Heart Problems	Y N	Skin Rash	Y N
Back Problems	Y N	Hepatitis Type _____		Special Diet	Y N
Bleeding abnormally, with extractions or surgery	Y N	Herpes	Y N	Stroke	Y N
Blood Disease	Y N	High Blood Pressure	Y N	Swollen Feet or Ankles	Y N
Cancer	Y N	Jaundice	Y N	Swollen Neck Glands	Y N
Chemical Dependency	Y N	Jaw pain	Y N	Thyroid Problems	Y N
Chemotherapy	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Circulatory Problems	Y N	Liver Disease	Y N	Tuberculosis	Y N
Congenital Heart Lesions	Y N	Low Blood Pressure	Y N	Tumor or growth on head or Neck	Y N
Cortisone Treatments	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
Cough, persistent or bloody	Y N	Nervous Problems	Y N	Venereal Disease	Y N
Diabetes	Y N	Pacemaker	Y N	Weith Loss, unexplained	Y N
Emphysema	Y N	Psychiatric Care	Y N	Osteoporosis	Y N
Do you wear contact lenses?	Y N	Radiation Treatment	Y N		

Women:

Are you pregnant? Y N

Due date: _____

Are you nursing? Y N

Taking birth control pills? Y N

MEDICATIONS

List any medications you are currently taking:

Pharmacy Name _____

Phone () _____

ALLERGIES

Aspirin	Y N	Local Anesthetic	Y N
Barbiturates (Sleeping pills)	Y N	Penicillin	Y N
Codeine	Y N	Sulfa	Y N
Iodine	Y N	Other _____	
Latex	Y N	_____	