INNOVATIVE
ORAL SURGERY & DENTAL IMPLANTS
LIVE IN COMFORT. SMILE WITH CONFIDENCE

Patient Registration & Health History

Name _____ ◯ Male ◯ Female DOB _____

Address _____ City _____ State _____ ZIP _____

Home # _____ Cell # _____ Work # _____ Pharmacy # _____

Emergency Contact Name _____ Phone # _____

S.S. # _____ Marital Status ..... ◯ Married ◯ Single

Family Dentist _____ Phone # _____ Family Physician _____ Phone # _____

Email _____ Whom may we thank for the referral? _____

Please give receptionist any insurance cards, forms, and X-rays.

Dental Insurance _____ Name of Insured _____ S.S. # _____

ID # _____ Group # _____ DOB _____ Relationship to Insured _____

Medical Insurance _____ Name of Insured _____ S.S. # _____

ID # _____ Group # _____ DOB _____ Relationship to Insured _____

Employer of Insured _____ Phone # _____ ◯ Full-Time ◯ Part-Time ◯ Retired

Address _____ City _____ State _____ ZIP _____

Who is financially responsible for this account? _____ Phone # _____

Please check yes or no if you have any of the following conditions:

Yes	No		Yes	No		Yes	No	
◯	◯	Anemia	◯	◯	Thyroid Disease	◯	◯	Seizure Disorder
◯	◯	Heart Murmur (or MVP)	◯	◯	Asthma	◯	◯	Kidney Disease
◯	◯	High Blood Pressure	◯	◯	Diabetes	◯	◯	History of Endocarditis
◯	◯	Heart Disease	◯	◯	Are You Pregnant?	◯	◯	Sleep Apnea/Snoring
◯	◯	Use Oral Contraceptives	◯	◯	Are You Nursing?	◯	◯	Rheumatic Fever
◯	◯	Artificial Joint/Heart Valve	◯	◯	History of Hepatitis: Type A/B/C	◯	◯	Tuberculosis
◯	◯	Allergic to Latex, Soy, or Egg	◯	◯	Nervous or Autoimmune Disorder	◯	◯	History of Radiation Therapy: Head/Neck

Any other conditions not listed above? _____

Have you taken Fosamax®, Boniva®, Actonel®, Zometa®, Aredia®, Prolia®, Xqeva®, or Avastin®? ..... ◯ Yes ◯ No

List any antibiotics, anesthetics, or other drugs you are allergic to _____

Have you taken any steroid medication (prednisone/cortisone) in the past 2 years? ..... ◯ Yes ◯ No

Have you ever had prolonged bleeding after a dental extraction, or at any time? ..... ◯ Yes ◯ No

List all prescription medications you are currently taking _____

_____

Do you have any disease, organ transplant, or take any medication which may depress your immune system? ◯ Yes ◯ No

Do you have, or have you ever had, clicking, popping, or pain in your temporomandibular joints (TMJ)? ◯ Yes ◯ No

Have you been hospitalized in the past 5 years? ..... ◯ Yes ◯ No Why? _____

Do you take aspirin on a daily basis? ..... ◯ Yes ◯ No Why? _____

Have you struggled with addiction? ..... ◯ Yes ◯ No Do you smoke? ..... ◯ Yes ◯ No How much? _____

Have you had **ANYTHING** to eat or drink in the past 6 hours? ..... ◯ Yes ◯ No

Is there anything you'd like to discuss with the doctor in private? _____

I attest that I understand and answered all the above questions honestly and completely. I understand that the doctor is basing his treatment on this information. I authorize the release of information to insurance carriers and other healthcare professionals who are involved in my care. I assign my insurance benefits to Innovative Oral Surgery & Dental Implants unless otherwise indicated.

Signature of Patient (Parent or Guardian if Minor) **Signature of Doctor** **Date**