ALFI
Oral, Dental Implant
& Facial Surgery
Texas Medical Center

6624 Fannin St, Ste 1710
Houston, TX 77030
P. (713) 489-6984
E. info@alfioralsurgery.com

PATIENT REGISTRATION

Patient's Name _____

Social Security _____ Date of Birth _____ Age _____ Sex: ☐ M ☐ F

Driver's License # _____ State _____ Status: ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Other

Home Phone # _____ Business Phone # _____ Cell # _____

Home Address _____ City _____ State _____ ZIP _____

Emergency Contact Name _____ Relation _____ Cell # _____

Student: ☐ Full Time ☐ Part Time ☐ Not School Name & Address _____

Who referred you to this office? _____

Phone # _____ Email _____

Person legally responsible for this account: Relation: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Name _____ Home # _____ Cell # _____

Street _____ City _____ State _____ ZIP _____

Employer Name _____

Primary Insurance Company

Insurance Information:

Insurance Co. Name _____

Address _____

_____

Phone _____

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group # _____ Local _____

Policyholder's Information:

Name _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex: ☐ M ☐ F Date of Birth _____

Street _____

City _____ State _____ ZIP _____

Phone _____

S.S. # _____ ID # _____

Secondary Insurance Company

Insurance Information:

Insurance Co. Name _____

Address _____

_____

Phone _____

Does your plan cover: ☐ Dental ☐ Medical ☐ Both

Group # _____ Local _____

Policyholder's Information:

Name _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Sex: ☐ M ☐ F Date of Birth _____

Street _____

City _____ State _____ ZIP _____

Phone _____

S.S. # _____

OFFICE POLICY REGARDING FINANCIAL ARRANGEMENTS AND INSURANCE

Each patient, not the insurance company, is responsible for payment of all charges to his/her account at the time services are rendered unless other arrangements are made in advance. Payments are expected within 10 days upon receipt of the office billing statement. I/we agree to pay collection costs and/or a reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection.

_____ _____

Signature of Patient (Parent or Guardian if Minor) Date

HEALTH HISTORY

State in your words the purpose of your visit: _____

_____

Are you now under a physician's care, or have you been during the past 5 years including hospitalization(s) and surgery? ☐ Yes ☐ No

If so, for what reason? _____

Name of physician _____ Phone # _____

Are you currently under a doctor's orders or taking any medications? ☐ Yes ☐ No

Please list _____

_____

_____

_____

Do you have any allergies, or are you sensitive to drugs such as penicillin, local anesthesia (lidocaine), aspirin, or codeine? ☐ Yes ☐ No

If so, please list _____

Are you allergic, or have you ever had an adverse reaction, to latex? ☐ Yes ☐ No

Have you ever bled excessively after a cut, wound, or surgery? ☐ Yes ☐ No

Have you ever received a blood transfusion? ☐ Yes ☐ No

Are you subject to fainting, dizziness, nervous disorders, convulsions, or epilepsy? ☐ Yes ☐ No

Have you ever had any breathing difficulty, asthma, emphysema, chronic cough, pneumonia, tuberculosis, or other lung disorder? Please describe: _____ ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have, or have you ever had, any of the following?

Heart Trouble	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	HIV	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	AIDS	☐ Yes	☐ No			

☐ Other _____

Your weight _____ Your height _____

Have you previously, or are you currently taking, bisphosphonate medication (Fosamax®, Pamidronate, Zometa®, Actonel®)? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

_____ _____

Signature of Patient (Parent or Guardian if Minor) Date

_____ _____

Signature of Doctor Date