ALFI
Oral, Dental Implant
& Facial Surgery
Texas Medical Center

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Houston, TX 77030
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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

What is the reason for visiting our practice? _____

_____

What is your height? _____ What is your weight? _____

Are you in good health? ☐ Yes ☐ No

Have there been any changes in your general health in the past year? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No

Have you had any illness, operation, or been hospitalized in the past five years? ☐ Yes ☐ No

Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth? ☐ Yes ☐ No

Do you have a prosthetic joint/implant? ☐ Yes ☐ No

Have you had a heart valve replacement or vascular graft? ☐ Yes ☐ No

Have you ever had general anesthesia? ☐ Yes ☐ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Is there any condition concerning your health that the doctor should be told about? ☐ Yes ☐ No

Do you wish to speak to the doctor privately about anything? ☐ Yes ☐ No

If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No

Who is driving you home? _____ Mobile Phone _____

Notify of pick-up status via ☐ Text ☐ Phone Call

Is There a Family History Of:

Cancer ☐ Yes ☐ No

Autism ☐ Yes ☐ No

Anesthesia Problems ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

WOMEN ONLY

Is there a possibility of pregnancy? ☐ Yes ☐ No

Expected delivery date? _____

Are you nursing? ☐ Yes ☐ No

Date of your last period? _____

Are you taking birth control pills? ☐ Yes ☐ No

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.

HEALTH HISTORY (CONT.)

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

Rheumatic Fever	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No
Damaged Heart Valves/Mitral Valve Prolapse	☐ Yes	☐ No	Convulsions/Epilepsy	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Trouble	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Chest Pain/Angina	☐ Yes	☐ No	Low Blood Sugar	☐ Yes	☐ No
Heart Attack(s)	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Are you on dialysis?	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	Swollen Ankles, Arthritis, or Joint Disease	☐ Yes	☐ No
Pneumonia, Bronchitis, or Chronic Cough	☐ Yes	☐ No	Osteoporosis/Osteopenia	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Osteonecrosis	☐ Yes	☐ No
Hay Fever/Sinus Problems	☐ Yes	☐ No	Stomach Ulcers/Acid Reflux	☐ Yes	☐ No
Snoring	☐ Yes	☐ No	Contagious Diseases	☐ Yes	☐ No
Sleep Apnea/CPAP	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Do you smoke or vape?	☐ Yes	☐ No	Problems With The Immune System? Possibly From Medication/Surgery, Etc.	☐ Yes	☐ No
If so, how much a day? _____					
Do you use marijuana?	☐ Yes	☐ No	A Tumor or Growth	☐ Yes	☐ No
Do you use chewing tobacco?	☐ Yes	☐ No	Delay in Healing	☐ Yes	☐ No
Difficult Breathing/Other Lung Trouble	☐ Yes	☐ No	Cancer, Radiation Therapy, or Chemotherapy	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Chronic Fatigue/Night Sweats	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Are you on a diet?	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	A History of Alcohol Abuse	☐ Yes	☐ No
Blood Disorder Such as Anemia	☐ Yes	☐ No	A History Of Drug Use	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No
Bleeding Tendency/Abnormal Bleed	☐ Yes	☐ No	Eye Disease/Glaucoma	☐ Yes	☐ No
Hepatitis, Jaundice, or Liver Disease	☐ Yes	☐ No	Mental Health Problems/Anxiety/Depression	☐ Yes	☐ No
Infectious Mononucleosis	☐ Yes	☐ No	Removable Dental Appliance	☐ Yes	☐ No
Gallbladder Trouble	☐ Yes	☐ No	Pain and Clicking of Jaws When Eating	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No			

Signature of Patient (Parent or Guardian if Minor) _____ Date _____

Signature of Doctor _____ Date _____