PATIENT REGISTRATION & HEALTH HISTORY

Please complete the following confidential information:

Referred by: ______________________

Reason for Visit: ______________________

Has anyone in your family ever been seen by a doctor in our practice? _______ **Whom?** ______________

Date: ______________________ **Chart #:** ______________________

Patient's Name: ______________________ (Last First MI) Male ❑ Female ❑

Patient's Date of Birth: ______________________ Age: _______ SSN #: ______________________

Address: ______________________ (Street City State Zip)

Home Phone: ( ) ______________________ Work Phone: ( ) ______________________

Employer: ______________________

Married ❑ Single ❑ Divorced ❑ Student ❑ School: ______________________

Spouse's Name: ______________________ (Last First MI) Work: ( ) ______________________

PARENT/GUARANTOR INFORMATION

Parent/Guarantor: ______________________ (Last First MI) Relationship to patient: ______________________

Address: ______________________ (Street City State Zip)

Home Phone: ( ) ______________________ Work: ( ) ______________________

Employer: ______________________ SSN #: ______________________

INSURANCE/PAYMENT INFORMATION

Please check the payment method most convenient for you: **Check or Cash** ❑ Visa/Mastercard ❑

Primary Insurance Dental ❑ Medical ❑

Insurance Co.: ______________________

Subscriber's Name: ______________________ (Last First)

Male ❑ Female ❑

Date of Birth: ______________ (of insured) SSN #: ______________ (of insured)

Group #: ______________________

Secondary Insurance Dental ❑ Medical ❑

Insurance Co.: ______________________

Subscriber's Name: ______________________ (Last First)

Male ❑ Female ❑

Date of Birth: ______________ (of insured) SSN #: ______________ (of insured)

Group #: ______________________

ASSIGNMENT & RELEASE

I acknowledge and agree that payment for services rendered is due at the time that such service is performed and that payment or payment arrangements must be made in accordance with terms of the Financial Policy of Atlanta Orthofacial Surgery Centers (AOFSC), which is expressly made a part of this agreement and I acknowledge receiving and reading a copy of the Financial Policy.

I authorized payment of benefits to AOFSC for services rendered under the terms of my insurance policy, but not to exceed the balance due of my account and for AOFSC to release any medical or other information necessary to process insurance claims. I further authorized photocopies of this form to be valid as the original.

X ______________________________ **DATE** ______________

HEALTH HISTORY

	YES	NO
1. Are you having pain or discomfort at this time?	❑	❑
2. Do you feel very nervous about having dental treatment?	❑	❑
3. Have you ever had a bad experience in the dental office?	❑	❑
4. Have you ever been a patient in the hospital during the past two years?	❑	❑
5. Have you been under the care of a medical doctor during the past two years?	❑	❑

Physician's Name ______________________________ Phone # ______________

Women:
Are you pregnant? ❑ Yes ❑ No If yes, what month? __________ Are you taking birth control pills? ❑ Yes ❑ No

	YES	NO
6. Have you taken any medicine or drugs during the past two years?	❑	❑
Are you now taking any medication, drugs, or pills?	❑	❑

If yes, please list: ______________________________

	YES	NO
7. Are you allergic or have you reacted adversely to any of the following medications?	❑	❑

Please check all that apply:

❑ Aspirin	❑ Nitrous Oxide	❑ Valium	❑ Local Anesthetic
❑ Darvon	❑ Erythromycin	❑ Scopolamine	❑ (Novocain or Xylocaine)
❑ Codeine	❑ Tetracycline	❑ Penicillin	❑ Sleeping Pills
❑ Demerol	❑ Percodan	❑ Other Antibiotics	❑ (Nembutal/Seconal)

	YES	NO
8. Are you aware of being allergic to any other medications or substance?	❑	❑

If yes, please list: ______________________________

9. Check any of the following which you have had or have at present:

YES	NO		YES	NO		YES	NO	
❑	❑	Heart Failure	❑	❑	Emphysema	❑	❑	HIV Positive and/or AIDS
❑	❑	Heart Disease or attack	❑	❑	Cough	❑	❑	Hepatitis A (Infectious)
❑	❑	Angina Pectoris	❑	❑	Tuberculosis (TB)	❑	❑	Hepatitis B (serum)
❑	❑	High Blood Pressure	❑	❑	Asthma	❑	❑	Liver Disease
❑	❑	Heart Murmur	❑	❑	Hay Fever	❑	❑	Yellow Jaundice
❑	❑	Rheumatic Fever	❑	❑	Sinus Trouble	❑	❑	Blood Transfusion
❑	❑	Congenital Heart Lesions	❑	❑	Allergies or Hives	❑	❑	Drug Addiction
❑	❑	Scarlet Fever	❑	❑	Diabetes	❑	❑	Hemophilia
❑	❑	Artificial Heart Valve	❑	❑	Thyroid Disease	❑	❑	Venereal Disease (Syphilis, Gonorrhea)
❑	❑	Heart Pacemaker	❑	❑	X-ray or Cobalt treatment	❑	❑	Cold Sores
❑	❑	Heart Surgery	❑	❑	Chemotherapy (Cancer, Leukemia)	❑	❑	Fever Blisters
❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Arthritis	❑	❑	Epilepsy or Seizures
❑	❑	Anemia	❑	❑	Rheumatism	❑	❑	Fainting or Dizzy Spells
❑	❑	Stroke	❑	❑	Cortisone Medicine	❑	❑	Nervousness
❑	❑	Kidney Trouble	❑	❑	Glaucoma	❑	❑	Psychiatric Treatment
❑	❑	Ulcers	❑	❑	Pain in Jaw Joints	❑	❑	Sickle Cell Disease
❑	❑	Cosmetic Surgery				❑	❑	Bruise Easily

	YES	NO
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	❑	❑
11. Have you lost or gained more than 10 pounds in the past year?	❑	❑
12. Are you currently taking any diet medication (Herbal, Phenfen, Redux)?	❑	❑
13. Are you on a special diet?	❑	❑
14. Has your medical doctor ever said you have a cancer or tumor?	❑	❑
15. Do you smoke cigarettes, cigars or pipe tobacco products?	❑	❑
16. Do you use smokeless tobacco products (chewing tobacco, snuff)?	❑	❑
17. Do you have any disease, condition, or problem not listed?	❑	❑

Antibiotics may interfere with the action of Oral Contraceptives (OC). If you use OC and are prescribed an antibiotic, it is recommended that you use additional contraceptive precautions while taking the medicine and for the following seven (7) days.

I certify that the information provided is true and accurate to the best of my knowledge.

Patient Signature ______________________________ Date ______________________