Oral and Maxillofacial Surgery and Implant Specialists of Middlesex
Patient Registration Form

DEMOGRAPHIC INFORMATION

Name: __________________________ (MI) ____ (Last)________________________________

Sex: (Male) ____ Female _____

Date of Birth: (Month) ___________________________ (Day) ___________ (Year) __________

Age: ________

Home Address:

(Street) ____

(Apartment/Suite)____

(City)_______________________________________ (State) ______ (Zip) ________

Email Address: ____

Telephone: (Home) (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

(Cell) (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

Driver's License #: ___________________________________ (State) ___________

Social Security Number: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

Marital Status: Married ( ) Divorced ( ) Legally Separated ( ) Single ( ) Widowed ( )

How were you referred to our practice? ____

Dentist ( ) Friend/Family Member ( ) Physician ( ) Orthodontist ( ) Not Referred

If you were not referred, how did you find us?

Insurance Company ( ) Internet Search Engine ( ) Social Media ( ) Mailing ( ) Advertisement

Who is your dentist: ____

Who is your orthodontist (if applicable) ____

Employed: Full Time ( ) Part Time ( ) Not Employed ( ) Retired ( )

Employer/Business: ____

Work Address:

(Street) ____

(Apartment/Suite)____

(City)_______________________________________ (State) ______ (Zip) ______

Telephone: (Work) (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

Second Employer/Business: ____

Work Address:

(Street) ____

(Apartment/Suite)____

(City)_____________________________________ (State) ______ (Zip) ______

Telephone: (Work) (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

Who is the responsible party for this account: Self ( ) Mother ( ) Father ( ) Spouse ( ) Other ( )

Are you a Student: Yes ( ) No ( )

If yes: Full Time Student ( ) Part Time Student ( )

School/University/College: ____

INSURANCE INFORMATION

Primary Dental Insurance

Employer/Business: __________________

____

Address:

(Street)_____________________________

(City)______________________________

(State) _______________ (Zip) _________

Phone: ______ - ______ - ________

Plan Name: _________________________

Insurance Company Name:

____

Address:

(Street)_____________________________

(City)______________________________

(State) _______________ (Zip) _________

Phone: ______ - ______ - ________

Group: _____________________________

Group Number: ______________________

Primary Medical Insurance

Employer/Business: __________________

____

Address:

(Street)_____________________________

(City)______________________________

(State) _______________ (Zip)__________

Phone: ______ - ______ - ________

Plan Name: _________________________

Insurance Company Name:

____

Address:

(Street)_____________________________

(City)______________________________

(State) _______________ (Zip) _________

Phone: ______ - ______ - ________

Group: _____________________________

Group Number: ______________________

Insured Party Name:

(First) ______________________________

(Last)________________________________

Date of Birth: __ __ /__ __/ __ __ __ __

Relation: ____________________________

Insured Sex: Male ( ) Female ( )

Insured Address:

Street: ______________________________

Apt/Suite: ___________________________

City: ________________________________

State: ______________ (Zip) ___________

Phone: ______ - ______ - ________

Policy ID Number: ___________________

Insured Party Name:

(First)________________________________

(Last)_________________________________

Date of Birth: __ __ /__ __/ __ __ __

Relation: ______________________________

Insured Sex: Male ( ) Female ( )

Insured Address:

Street: _______________________________

Apt/Suite: _____________________________

City: _________________________________

State: ___________________ (Zip) ______

Phone: ______ - ______ - ________

Policy ID Number______________________

Secondary Dental Insurance

Employer/Business: ___________________

____

Address:

(Street)______________________________

(City) _______________________________

(State) _________________ (ZIP) _______

Phone: ______ - ______ - ________

Plan Name: ___________________________

Insurance Company Name:

____

Address:

(Street)______________________________

(City) _______________________________

(State) _________________ (ZIP) _______

Phone: ______ - ______ - ________

Group: _______________________________

Group Number: _______________________

Secondary Medical Insurance

Employer/Business: ____________________

____

Address:

(Street) ______________________________

(City) _______________________________

(State) ____________________ (ZIP) _____

Phone: ______ - ______ - ________

Plan Name: ____________________________

Insurance Company Name:

____

Address:

(Street) ______________________________

(City) _______________________________

(State) ____________________ (ZIP) _____

Phone: ______ - ______ - ________

Group: _______________________________

Group Number: _______________________

Insured Party Name:

(First) ______________________________

(Last) ______________________________

Date of Birth: __ __ / __ __ / __ __ __ __

Relation: ____________________________

Insured Sex: Male ( ) Female ( )

Insured Address:

(Street)_____________________________

(City) ______________________________

(State) _________________ (ZIP) _______

Phone: ______ - ______ - ________

Policy ID Number: __________________

Insured Party Name:

(First) ______________________________

(Last) ______________________________

Date of Birth: __ __ / __ __ / __ __ __ __

Relation: ____________________________

Insured Sex: Male ( ) Female ( )

Insured Address:

(Street) _____________________________

(City) ______________________________

(State) ___________________ (ZIP) _____

Phone: ______ - ______ - ________

Policy ID Number_____________________

Continue →

HEALTH HISTORY

Who is your Medical Doctor: ____

Internal Medicine ( ) Family Medicine ( ) Pediatrician ( ) Ob/Gyn ( ) Other ( )

Phone Number: (__ __ __) - __ __ __ - __ __ __ __

Address: ____

How long have you been under your doctor's care: ____________________________

When was the last time you were seen by your doctor: __________________________

When is your next appointment with your doctor: _____________________________

Has there been any recent change in your medical history: Yes ( ) No ( )

If yes, please describe: ____

____

____

Have you gained or lost more than 10 pounds in the last year? Yes ( ) No ( )

Do you smoke? Yes ( ) No ( )

If yes, how many cigarettes do you smoke per day: __________________________

How long have you been a smoker? ______________________________________

Do you normally take antibiotics prior to dental procedures? Yes ( ) No ( )

Have you ever had a prosthetic joint replacement? Yes ( ) No ( ) Date of surgery: ________

Do you have [or ever had] (1.) a prosthetic heart valve, (2.) a history of endocarditis, (3.) recent surgery to correct a congenital heart defect, (4.) unrepaired congenital heart defect?

Yes ( ) No ( )

Have you ever taken medications to fight osteoporosis, metastatic bone disease, or multiple myeloma such as Fosamax, Boniva, Actonel, Zometa, Aredia or Xgeva (Denosumab)?

Yes ( ) No ( ). If yes, how long have you been taking this medication: ___________

Have you ever had Radiation to the head or neck for treatment, eg.cancer? Yes ( ) No ( )

Are you pregnant, trying to get pregnant, or may be pregnant now: Yes ( ) No ( )

Have you ever had problems with general anesthesia? Yes ( ) No ( )

If yes, please elaborate: ____

____

____

Height: ___________ Weight: __________

Do you have or ever had:

Asthma	*yes*	*no*
Snoring, Obstructive Sleep Apnea (OSA)	*yes*	*no*
Chronic Bronchitis	*yes*	*no*
Emphysema	*yes*	*no*
Shortness of breath	*yes*	*no*
Pulmonary Embolus	*yes*	*no*
Chest pain	*yes*	*no*
Heart Attack	*yes*	*no*
Revascularization Surgery (CABG, PTCA)	*yes*	*no*
Rheumatic Fever	*yes*	*no*
Heart Valve Disease/Mitral Valve Prolapse/Aortic Stenosis	*yes*	*no*
Irregular Heart Beat/Arrythmia (eg. Atrial Fibrillation)	*yes*	*no*
Cardiac Defibrillator or Pacemaker	*yes*	*no*
Hypertension	*yes*	*no*
Hypercholesterolemia	*yes*	*no*
Cardiomyopathy	*yes*	*no*
Congenital Heart Defect	*yes*	*no*
Diabetes	*yes*	*no*
Kidney Disease	*yes*	*no*
Are you on Dialysis?	*yes*	*no*
Liver Disease (eg. Hepatitis)	*yes*	*no*
Gall Bladder Disease (cholecystitis, choledocholithiasis, etc.)	*yes*	*no*
Pancreatitis	*yes*	*no*
Low or High Thyroid	*yes*	*no*
Adrenal Insufficiency	*yes*	*no*
Swelling of the feet, ankles, or calf	*yes*	*no*
Gastric Reflux (GERD)	*yes*	*no*
Gastric or Duodenal Ulcer	*yes*	*no*
Hiatal Hernia	*yes*	*no*
Crohn’s Disease/Ulcerative Colitis	*yes*	*no*
Cerebrovascular Disease (Stroke)	*yes*	*no*
Parkinson’s Disease	*yes*	*no*
Epilepsy (Seizures)	*yes*	*no*
TMJ pain/clicking	*yes*	*no*
Psychiatric disease (Bipolar, Schizophrenia, Depression, Anxiety)	*yes*	*no*
Tuberculosis	*yes*	*no*
Sexually Transmitted Disease	*yes*	*no*
HIV	*yes*	*no*
Cancer; Chemotherapy, Radiation Treatment	*yes*	*no*
Blood Disorder (Anemia, Lymphoma/Leukemia, etc.)	*yes*	*no*

List any other disease(s)/ailment(s) you have been diagnosed, not previously mentioned: ______

____

____

Do you take Coumadin? Yes ( ) No ( )

Do you take other blood thinners? (eg. Pradaxa, Aspirin, Ginko, Xarelto) Yes ( ) No ( )

Do you bruise easily? Yes ( ) No ( )

Have you ever needed a blood transfusion? Yes ( ) No ( )

Do you have a history of alcohol abuse? Yes ( ) No ( )

Do you have a history of drug abuse? Yes ( ) No ( )

Medications:

1. __________________ 2. __________________ 3. __________________

4. __________________ 5. __________________ 6. __________________

7. __________________ 8. __________________ 9. __________________

10. _________________ 11. _________________ 12. _________________

Allergy:

Are you allergic or ever had an allergic reaction to:

Penicillins	*yes*	*no*
Other Antibiotics	*yes*	*no*
Sulfa Drugs	*yes*	*no*
Local Anesthetic (Lidocaine)	*yes*	*no*
Soy/Egg/Yolk	*yes*	*no*
Latex	*yes*	*no*
Morphine/Narcotics	*yes*	*no*
Valium/Xanax	*yes*	*no*
Nonsteroidal Anti-Inflammatory (eg. aspirin, ibuprofen)	*yes*	*no*

Medication: ____

Is there anything else you would like to discuss with the doctor? : ______________________

____

This patient registration form has been completed to the best of my knowledge and ability, as of today, __ __ / __ __ / __ __ __ __.

X

Patient

Patient/Guarantor