Oral & Maxillofacial Surgery Specialists, P.C.
8580 Scarborough Dr., Suite 240
Colorado Springs, CO 80920

PATIENT REGISTRATION

PLEASE PRINT COMPLETE ANSWERS TO ALL QUESTIONS. This is a confidential record.

PATIENT_____ **PREFERRED NAME**_____ **DATE**_____
last name first name middle name

Circle one: Miss Mrs. Ms. Mr. Dr. Rev. Date of Birth _____ E-mail _____

S.S. # _____ Telephone #_____ Cell Phone #_____

Residence Address _____

City_____ State _____ Zip Code_____

Occupation_____ Employer/School_____ Work Phone _____

Parent /Guardian (if Minor)_____ Home Phone _____

Address _____ S.S.# _____

Occupation_____ Employer _____ Work Phone _____

INSURANCE INFORMATION:

Dental: Insurance Co: _____ Subscriber: _____ (Birthdate)

I.D. #:_____ SSN_____ Group #: _____

Secondary Insurance Co: _____ Subscriber: _____ (Birthdate)

I.D. #:_____ SSN_____ Group #: _____

Medical: Insurance Co: _____ Subscriber: _____ (Birthdate)

I.D. #:_____ SSN_____ Group #: _____

Secondary Insurance Co: _____ Subscriber: _____ (Birthdate)

I.D. #:_____ SSN_____ Group #: _____

Employer _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name_____ Relationship _____

Address _____ Home Telephone #_____

City _____ Zip _____ Work Telephone # _____

Please print name of person or doctor who referred you to this office:

Name _____

Have you or has any member of your family ever been a patient in our office prior to today? YES NO (Circle one)

If Yes, name of patient and approximate date of treatment: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Medical & Dental History

PHYSICIAN'S NAME:_____ DATE OF LAST PHYSICAL EXAM:_____

PRESENT COMPLAINT OR PROBLEM: _____

_____

Y	N	HEART PROBLEMS	Y	N	GLAUCOMA
Y	N	MURMUR/VALVULAR DEFECTS	Y	N	FAINTING SPELLS
Y	N	RHEUMATIC FEVER	Y	N	EPILEPSY,CONVULSIONS, SEIZURES
Y	N	CONGENITAL HEART DISEASE	Y	N	DIABETES
Y	N	HEART ATTACK	Y	N	LIVER DISEASE (HEPATITIS/JAUNDICE/CIRRHOSIS)
Y	N	CHEST PAIN	Y	N	KIDNEY DISEASE
Y	N	HIGH BLOOD PRESSURE	Y	N	STOMACH ULCER/GASTRO/ESOPHAGEAL REFLUX
Y	N	FREQUENTLY SWOLLEN ANKLES	Y	N	VENEREAL DISEASE
Y	N	SHORTNESS OF BREATH	Y	N	BLEEDING PROBLEMS/ANEMIA/BLOOD THINNER
Y	N	LUNG DISEASE/PERSISTANT COUGH	Y	N	BRUISING
Y	N	PNEUMONIA	Y	N	ARTHRITIS
Y	N	SMOKE OR CHEW TOBACCO	Y	N	REACTION TO ANESTHESIA (ANY RELATIVES)
Y	N	ALCOHOL	Y	N	RADIATION THERAPY
Y	N	RECREATIONAL DRUGS	Y	N	MALIGNANCIES
Y	N	ASTHMA, HAY FEVER ALLERGIES	Y	N	ARE YOU PREGNANT/BREAST FEEDING
Y	N	STROKE OR TIA	Y	N	DO YOU WEAR CONTACT LENSES
Y	N	THYROID DISEASE	Y	N	SINUS OR NASAL PROBLEM
Y	N	FREQUENT SORES IN MOUTH	Y	N	DO YOU PLAY A WIND INSTRUMENT

Are you allergic to latex (rubber gloves, balloons, elastic)? _____
Have you ever been hospitalized or had previous surgeries? _____
If yes, explain _____

_____

Are you allergic to, or had a reaction to drugs/medications (penicillin, sulfa)?_____
If yes, explain _____
Are you taking any pills, medications, herbal and/or dietary supplements? _____
If yes explain _____
Are you taking or have you taken Fosamax, Zometa, Boniva, Actonel or Reclast?_____
Please describe any current medical treatment, impending operations or any other medical or dental information that may possibly affect you treatment _____

_____

DENTIST NAME: _____ DATE OF LAST DENTAL EXAM: _____

Any complications with dental treatment? _____ If so, explain. _____
Do you clench or grind your teeth? _____ Any pain in or around the ears? _____
Does your jaw pop, click or grind? _____If so, please describe. _____

Additional Comments _____

_____

I UNDERSTAND THE INPORTANCE OF A TRUTHFUL HEALTH HISTORY TO ASSIST THE BEST CARE POSSIBLE. I HAVE HAD THE OPPORTUNITY TO DISCUSS MY HEALTH HISTORY WITH MY DOCTOR.

X _____/_____

SIGNATURE OF PERSON COMPLETING HEALTH HISTORY SIGNATURE OF DOCTOR DATE

MEDICAL UPDATE: I have read my health history dated ____/_____/____ and confirm that it adequately states past and present conditions.

_____	_____	_____	_____
DATE	EXCEPTIONS OR CHANGES	PATIENT SIGN	DOCTOR

Oral and Maxillofacial Surgery Specialists, P.C.

Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means. such as sending correspondence to the individuals office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or cellular telephone
- ☐ O.K. to leave message with the detailed information
- ☐ Leave message with call-back number only

- ☐ Work telephone:
- ☐ O.K. to leave message with detailed information

- ☐ Written communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to Email Email address: _____
- ☐ O.K. to text cell Cell # _____

I allow you to give my clinical information to or answer questions from (check all that apply):

- ☐ Spouse Name: _____
- ☐ Parent(s) Name(s): _____
- ☐ Child Name: _____
- ☐ Other (Specify): _____
- ☐ None

_____ _____

Patient Signature (if Minor Parent Sign) Date

_____

Print Name