PATIENT REGISTRATION

DATE:_____ HOME PHONE_____

PATIENT NAME_____ I PREFER TO BE CALLED_____

STREET ADDRESS_____ SOC. SEC. NO._____

CITY_____ STATE_____ ZIP CODE_____

CELL PHONE_____ WORK_____ E-MAIL_____

SEX [] M [] F AGE_____ BIRTH DATE_____ DRIVER'S LICENSE# _____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

CITY_____ STATE_____ ZIP CODE_____

REFERRED BY_____ PHONE_____

May we contact You, a Spouse, Family or friends regarding your health information. Including leaving messages at your home number, sending written mail and the same at your place of employment? Yes No

ACCOUNT HOLDER (if patient is a minor only)

NAME_____ RELATIONSHIP_____

ADDRESS (If different than patients)_____

PHONE_____ CELL PHONE_____

SOC. SEC. NO._____ BIRTH DATE_____ DRIVER'S LICENSE_____

DENTAL INSURANCE

NAME OF INSURED_____ SEX [] M [] F

SOC. SEC. NO._____ BIRTH DATE_____ PHONE_____

EMPLOYER_____

BUSINESS ADDRESS_____

DENTAL INSURANCE CO._____ PHONE_____

GROUP NO._____ I.D. NO._____

SECONDARY/MEDICAL INSURANCE

PATIENT COVERED BY ADDITIONAL INSURANCE? []YES []NO [] MEDICAL [] DENTAL

NAME OF SECONDARY DENTAL INSURANCE:_____

NAME OF INSURED_____ SOC. SEC. NO._____ BIRTH DATE_____

GROUP NO._____ I.D. NO._____

INSURANCE ADDRESS_____ PHONE_____

NAME OF MEDICAL INSURANCE:_____

NAME OF INSURED_____ SOC. SEC. NO._____ BIRTH DATE_____

GROUP NO._____ I.D. NO._____ PHONE_____

MEDICAL ADDRESS_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
_____ Name of Ins. Company (ies)
and assign directly to San Tan Oral Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Signature of Responsible Party Relationship Date

HEALTH HISTORY

PATIENT NAME_____ BIRTHDATE____/____/____ PATIENT #_____

This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Today's date_____
Occupation_____
Previous occupations_____
Marital status_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit_____
Alcohol (type & amount per week)_____
Street drugs (type & amount per day)_____
Usual weight_____My ideal weight_____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)
_____
_____
_____

When was your last physical exam?_____
Name of doctor_____Phone_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:
_____
_____
_____

Please list all medicines you are currently taking (include nonprescription drugs):
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):
_____
_____
_____

Any history of family violence?_____

CHIEF COMPLAINTS
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____
_____

PAST MEDICAL HISTORY
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	nervous system problems	no	yes	Mitral Valve Prolapse	no	yes
Mumps	no	yes	Cancer	no	yes	Stroke	no	yes
Chickenpox	no	yes	Polio	no	yes	Hepatitis	no	yes
Scarlet Fever	no	yes	Glaucoma	no	yes	Ulcer	no	yes
Diptheria	no	yes	Sinus problems	no	yes	Kidney disease	no	yes
Smallpox	no	yes	Blood or Plasma Transfusions	no	yes	Thyroid Disease	no	yes
Pneumonia	no	yes	Back trouble	no	yes	Bleeding Tendency	no	yes
Rheumatic Fever	no	yes	High/low Blood Pressure	no	yes	Any other Disease	no	yes
Heart Disease	no	yes	Artificial joints	no	yes	(Please list)		
Arthritis	no	yes	MS/MD/Cerebral Palsy	no	yes	_____		
Venereal Disease	no	yes	Asthma	no	yes	Date of last Chest x-ray:		
Anemia	no	yes	Psychiatric care	no	yes	_____		
Hemophilia	no	yes	AIDS or HIV+	no	yes	Are you pregnant?	no	yes
Pacemaker	no	yes	Infectious Mono	no	yes	**Allergies to anesthetics**	no	yes
Epilepsy	no	yes	Bronchitis	no	yes			
Migraine Headaches	no	yes						
Tuberculosis	no	yes						
Diabetes	no	yes						

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature_____Date_____

_____
_____
_____Physicians Signature_____