SOUTHWEST
ORAL FACIAL & IMPLANT SURGERY

PATIENT REGISTRATION

Date:_____ Home phone: _____ Cell phone:_____
Best number to reach you about appointments? : Home or Cell

Patient: _____ Marital Status:_____
Last Name First Name Middle Initial

E-mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Sex: M ____ F ____ Age: _____ Birth Date: _____S.S. # _____

Employer: _____ Employer Phone: _____

Spouse Name: _____ Spouse's Employer: _____ Employer Phone: _____

Closest relative not living with you: _____ Phone: _____

Whom may we thank for referring you?_____

Who is your General Dentist?_____

MEDICAL HISTORY

Physician's Name: _____ Date of Last Physical: _____
Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Heart Problems	___	___	Sinus Problems	___	___	Nervous Problems
___	___	Artificial Heart Valves	___	___	Stroke	___	___	Psychiatric Care
___	___	Artificial Joints	___	___	Blood disease	___	___	Chemical Dependency
___	___	Rheumatic Fever, Murmur	___	___	Bleeding Disorder	___	___	Back Problems
___	___	High Blood Pressure	___	___	Hepatitis, Jaundice	___	___	Arthritis
___	___	Shortness of Breath			or Liver Disease	___	___	Venereal Disease
___	___	Circulatory Problems	___	___	Kidney Disease	___	___	AIDS / Other Immuno-
___	___	Lung Disorder	___	___	Chronic Diarrhea			suppressive Disorder
___	___	Asthma	___	___	Ulcer	___	___	Allergies to Anesthetic
___	___	Thyroid Disease	___	___	Diabetes	___	___	Allergies to Medicines
___	___	Epilepsy	___	___	Special Diet			or Drugs
___	___	Headaches	___	___	Recent Weight Loss	___	___	General Allergies
___	___	Swollen Neck Glands	___	___	Cancer	___	___	Sleep Apnea (use
___	___	Radiation Treatment						CPAP)

Do you have any drug allergies or have you ever had any adverse reaction to any medication? _____ If so, please explain
_____

Have you ever responded adversely to medical or dental treatment? _____

List all current medications and supplements you are taking, if you are not taking any please write N/A? _____

_____

_____

Are you taking any medications for osteoporosis such as Bisphosphonates? (i.e. Zometa, Aredia, Fosamax, Actonel, Boniva)
___ Yes ___ No If Yes, Name of Drug_____ was taken by IV_____ or by Oral _____?

Are you under the care of a physician? ___ Yes ___ No For what condition? _____

Do you use tobacco? ___Yes ___ No If yes: do you ___ *Smoke(cigarettes) or use Smokeless (*Chewing tobacco) Frequency: _____ Do you Vape? _____Yes ____No

Female Patients: Do you suspect that you are pregnant? _____Yes ___ No Trimester ____ Are you nursing? ____Yes ____ No

PERSON RESPONSIBLE FOR PAYMENT

If you are a **parent bringing a minor**, the signer of the registration and financial agreement will be listed as the responsible party.
(If you are **18 years of age** or older **you** are the person responsible and signing all forms.)

Name _____ Circle one (Self, Parent, Legal Guardian)

P.O. Box /
Street Address: _____ Home Phone: _____

_____ Work Phone: _____

Employer: _____ Cellular / Daytime Phone: _____

Responsible Party's Driver's License Number: _____ S.S. #: _____

Date of Birth _____

INSURANCE INFORMATION

Medical / Dental Insurance is a contract between the insured and the insurance carrier. The patient is responsible to our office for the total fees charged for services rendered. We are happy to bill your insurance company as a service to you if you supply us with the necessary information.

Primary Medical / Dental (Circle One)

Insurance Company: _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Employer: _____

Member ID.#:_____

Relationship to Patient_____

Insur Co Address: _____

_____

Phone #: _____

Secondary Medical / Dental (Circle One)

Insurance Company_____

Name of Policy Holder: _____

Date of Birth of Policy Holder:_____

Employer: _____

Member ID.#:_____

Relationship to Patient_____

Insur Co. Address.: _____

_____

Phone #:_____

The information on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors of omission that I may have made in completing the form.

I have read and / or been furnished with a copy of the "Notice of Privacy Practices" for Dixie Oral, Maxillofacial and Implant Surgery.

I agree to pay in full all fees that are incurred during my dental treatment or treatment of the above patient. I also understand that I am responsible for any balance not paid by my insurance company.

_____ _____ _____ _____

Patient's Signature Date Parent / Guardian's Signature Date