HARBOR ORAL SURGERY PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____ Age _____
Address _____ Zip Code _____ Phone _____
Social Security Number _____ Patient's Employer _____
Business Phone _____ Occupation _____
Spouse or Parent's Name _____
Address (if different from above) _____ Phone _____
Spouse or Parent's Employer _____
Who may we thank for referring you to our office? _____
Names of other family members we may have treated? _____

INSURANCE/RESPONSIBLE PARTY INFORMATION

Name of Insurance Company (primary) _____ ID# _____ Group# _____
Name of Subscriber _____ Date of Birth _____ SS# _____
Name of Insurance Company _____ ID# _____ Group# _____
Name of Subscriber _____ Date of Birth _____ SS# _____

MEDICAL AND DENTAL HISTORY

Name of Dentist _____

1. Are you under medical treatment now? Yes No
2. Have you had any major surgery? Yes No
   If yes, what type and when?
   _____
   _____
3. Have you had an adverse reaction to: (please check)
   - ____ penicillin
   - ____ other antibiotics
   - ____ codeine
   - ____ anesthetics of any kind
   - ____ any other medication
4. Has a doctor ever informed you that you have or have had: *(please check)*
   - ____ heart trouble
   - ____ heart murmur
   - ____ diabetes
   - ____ rheumatic fever
   - ____ arthritis
   - ____ tumors or growths
   - ____ any blood disease
   - ____ AIDS, HIV, ARC
   - ____ bleeding problems
   - ____ liver disease
   - ____ kidney disease
   - ____ ulcers
   - ____ venereal disease
   - ____ herpes
   - ____ high blood pressure
   - ____ hepatitis
   - ____ a stroke
   - ____ asthma, emphysema or lung problems
   - ____ eye disorders or contacts
   - ____ thyroid
   - ____ sinus problems
   - ____ cough
   - ____ emotional or neurological problems

Name of Physician _____

5. Have you ever had surgery to replace a joint? Yes No
6. Do you have any allergies? Yes No
   _____
   _____
7. Are you pregnant? Yes No
8. Have you ever had radiation treatment? Yes No
9. Please list any medications that you are currently taking: Yes No
   _____
   _____
10. If you are currently under medical treatment please explain below: _____
    _____
    _____
11. Have you or any family member had problems associated with general anesthesia? _____
    _____
12. Have you had an injury of your mouth or teeth or any problems associate with dental treatment? _____
    _____
    _____
13. Have you ever been hospitalized? _____
    _____
14. Do you use tobacco? Yes No
    If yes, pack(s) per day x year _____
15. Do you consume alcohol? Yes No
16. Do you have a history of recreational or IV drug use? Yes No

To the best of my knowledge, the above information is correct and current. I/We, the undersigned herewith give consent to secure x-rays and to perform whatever diagnostic procedures are necessary for determination of a treatment plan.

Date _____ Patient _____ Date _____ Guardian _____